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Part I

SALUS POPULI SUPREMA LEX ESTO

“The welfare of the people shall be the supreme law.”



JOHN R. ASHCROFT
SECRETARY OF STATE

MISSOURI REGISTER

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Register Filing Deadlines	Register Publication Date	Code Publication Date	Code Effective Date
August 1, 2018	September 4, 2018	September 30, 2018	October 30, 2018
August 15, 2018	September 17, 2018	September 30, 2018	October 30, 2018
September 4, 2018	October 1, 2018	October 31, 2018	November 30, 2018
September 17, 2018	October 15, 2018	October 31, 2018	November 30, 2018
October 1, 2018	November 1, 2018	November 30, 2018	December 30, 2018
October 15, 2018	November 15, 2018	November 30, 2018	December 30, 2018
November 1, 2018	December 3, 2018	December 31, 2018	January 30, 2019
November 15, 2018	December 17, 2018	December 31, 2018	January 30, 2019
December 3, 2018	January 2, 2019	January 29, 2019	February 28, 2019
December 17, 2018	January 15, 2019	January 29, 2019	February 28, 2019

Documents will be accepted for filing on all regular workdays from 8:00 a.m. until 5:00 p.m. We encourage early filings to facilitate the timely publication of the *Missouri Register*. Orders of Rulemaking appearing in the *Missouri Register* will be published in the *Code of State Regulations* and become effective as listed in the chart above. Advance notice of large volume filings will facilitate their timely publication. We reserve the right to change the schedule due to special circumstances. Please check the latest publication to verify that no changes have been made in this schedule. To review the entire year's schedule, please check out the website at www.sos.mo.gov/adrules/pubsched.

HOW TO CITE RULES AND RSMO

RULES

The rules are codified in the *Code of State Regulations* in this system–

Title		Division	Chapter	Rule
3	CSR	10-	4	.115
Department	<i>Code of State Regulations</i>	Agency Division	General area regulated	Specific area regulated

and should be cited in this manner: 3 CSR 10-4.115.

Each department of state government is assigned a title. Each agency or division in the department is assigned a division number. The agency then groups its rules into general subject matter areas called chapters and specific areas called rules. Within a rule, the first breakdown is called a section and is designated as (1). Subsection is (A) with further breakdown into paragraphs 1., subparagraphs A., parts (I), subparts (a), items I. and subitems a.

The rule is properly cited by using the full citation, for example, 3 CSR 10-4.115 NOT Rule 10-4.115.

Citations of RSMo are to the *Missouri Revised Statutes* as of the date indicated.

Code and Register on the Internet

The *Code of State Regulations* and *Missouri Register* are available on the Internet.

The *Code* address is www.sos.mo.gov/adrules/csr/csr

The *Register* address is www.sos.mo.gov/adrules/moreg/moreg

These websites contain rulemakings and regulations as they appear in the *Code* and *Registers*.

Rules appearing under this heading are filed under the authority granted by section 536.025, RSMo 2016. An emergency rule may be adopted by an agency if the agency finds that an immediate danger to the public health, safety, or welfare, or a compelling governmental interest requires emergency action; follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances; follows procedures which comply with the protections extended by the *Missouri* and the *United States Constitutions*; limits the scope of such rule to the circumstances creating an emergency and requiring emergency procedure, and at the time of or prior to the adoption of such rule files with the secretary of state the text of the rule together with the specific facts, reasons, and findings which support its conclusion that there is an immediate danger to the public health, safety, or welfare which can be met only through the adoption of such rule and its reasons for concluding that the procedure employed is fair to all interested persons and parties under the circumstances.

Rules filed as emergency rules may be effective not less than ten (10) days after filing or at such later date as may be specified in the rule and may be terminated at any time by the state agency by filing an order with the secretary of state fixing the date of such termination, which order shall be published by the secretary of state in the *Missouri Register* as soon as practicable.

All emergency rules must state the period during which they are in effect, and in no case can they be in effect more than one hundred eighty (180) calendar days or thirty (30) legislative days, whichever period is longer. Emergency rules are not renewable, although an agency may at any time adopt an identical rule under the normal rulemaking procedures.

**Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 41—General Tax Provisions**

EMERGENCY AMENDMENT

12 CSR 10-41.010 Annual Adjusted Rate of Interest. The Director of Revenue proposes to amend section (1) to reflect the interest to be charged on unpaid, delinquent taxes.

PURPOSE: *This emergency amendment establishes the annual adjusted rate of interest to be implemented and applied on taxes remaining unpaid during calendar year 2019.*

EMERGENCY STATEMENT: *The Director of Revenue is mandated to establish not later than October 22 annual adjusted rate of interest based upon the adjusted prime rate charged by banks during September of that year as set by the Board of Governors of the Federal Reserve rounded to the nearest full percent. This emergency amendment is necessary to ensure public awareness and to preserve a compelling governmental interest requiring an early effective date in that the amendment informs the public of the established rate of interest to be paid on unpaid amounts of taxes for the 2019 calendar year. A proposed amendment, that covers the same material, is published in this issue of the *Missouri Register*. The director has limited the scope of the emergency amendment to the circumstances creating the emergency. The director has followed procedures calculated to assure fairness to all interested persons and parties and has complied*

*with protections extended by the *Missouri* and *United States Constitutions*. This emergency amendment was filed October 22, 2018, becomes effective January 1, 2019, and expires June 29, 2019.*

(1) Pursuant to section 32.065, RSMo, the Director of Revenue upon official notice of the average predominant prime rate quoted by commercial banks to large businesses, as determined and reported by the Board of Governor/'s of the Federal Reserve System in the Federal Reserve Statistical Release H.15(519) for the month of September of each year has set, by administrative order, the annual adjusted rate of interest to be paid on unpaid amounts of taxes during the succeeding calendar year as follows:

Calendar Year	Rate of Interest on Unpaid Amounts of Taxes
1995	12%
1996	9%
1997	8%
1998	9%
1999	8%
2000	8%
2001	10%
2002	6%
2003	5%
2004	4%
2005	5%
2006	7%
2007	8%
2008	8%
2009	5%
2010	3%
2011	3%
2012	3%
2013	3%
2014	3%
2015	3%
2016	3%
2017	4%
2018	4%
2019	5%

AUTHORITY: *section 32.065, RSMo 2016. Emergency rule filed Oct. 13, 1982, effective Oct. 23, 1982, expired Feb. 19, 1983. Original rule filed Nov. 5, 1982, effective Feb. 11, 1983. For intervening history, please consult the *Code of State Regulations*. Emergency amendment filed Oct. 22, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed amendment covering this same material is published in this issue of the *Missouri Register*.*

**Title 19—DEPARTMENT OF HEALTH AND
SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 1—Controlled Substances**

EMERGENCY AMENDMENT

19 CSR 30-1.002 Schedules of Controlled Substances. The department is amending section (1) Schedules of Controlled Substances.

PURPOSE: *This emergency amendment updates the list of all drugs falling within the purview of controlled substances to match the corresponding list promulgated by the Drug Enforcement Administration (DEA).*

EMERGENCY STATEMENT: Since this rule was last amended, the DEA has issued several scheduling actions, all but two (2) of which have included adding drugs to the Schedule One list – the list of unlawful controlled substances used illicitly as street drugs. Adding these drugs to Schedule One allows municipal, county, and state law enforcement and prosecutors to enforce crimes related to these drugs; if the drugs are not scheduled, there are no criminal consequences for their unlawful use, possession, sale, or manufacture. The majority of drugs being added to Schedule One are synthetic drugs created when illicit organizations have slightly altered the molecular and chemical compound structure so the new drug does not fall under previous restrictions. This constant restructuring forces the DEA and states to continuously update their schedule lists with the new compounds in order to protect the public's health and safety. Drugs like synthetic fentanyl can now be included in Schedule One and combatted to avoid their further contributions to the state's opioid crisis related deaths and overdoses. A generic version of an isomer THC, the primary psychoactive substance in marijuana, is being added to Schedule Two for the treatment of anorexia associated with weight loss in patients with AIDS and for the treatment of nausea and vomiting resulting from cancer chemotherapy in patients who failed to respond to conventional anti-emetic therapies. Finally, approved cannabidiol drugs have been added to Schedule Five. Missouri enacted previous legislation to allow two (2) companies in Missouri to manufacture and dispense cannabidiol (CBD oil) drugs for patients with intractable seizures. However, because the drug was not approved by the FDA and the DEA, it was not covered by insurance and patients were forced to pay cash and could only receive the medication from select distributors. Since 2014, 367 Hemp Extract Registration Cards have been issued in Missouri, with 184 cards still being active, including 124 cards issued to minors. Recently, a new cannabidiol drug has been approved by the FDA and the DEA. The emergency scheduling of this drug in Schedule Five will allow Missouri physicians to prescribe these drugs to Missouri patients for seizures, wasting syndrome, nausea, and for the more effective pain management through the reduction of opiate use. These drugs will be available in pharmacies by prescription and covered by insurance, greatly increasing their accessibility to patients in need. This emergency amendment is necessary for the immediate protection of the public health, safety, and welfare due to the risk created by unregulated illicit drugs and also by the increased treatment potential of making approved Schedule Two and Five drugs available for use. The department finds a compelling governmental interest in protecting the public health, safety, and welfare, which requires this emergency action. A proposed amendment, which covers the same material, is published in this issue of the *Missouri Register*. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the *Missouri and United States Constitutions*. The department believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed October 25, 2018, becomes effective November 4, 2018, and expires May 2, 2019.

(1) Schedules of Controlled Substances.

(A) Schedule I shall consist of the drugs and other substances[,/] by whatever official name, common or usual name, chemical name, or brand name designated[,/] listed in this section. Each drug or substance has been assigned the Drug Enforcement Administration (DEA) Controlled Substances Code Number set forth opposite it.

1. Opiates. Unless specifically excepted or unless listed in another schedule, any of the following opiates, including their isomers, esters, ethers, salts, and salts of isomers, esters and ethers, whenever the existence of such isomers, esters, ethers, and salts is possible within the specific chemical designation:

- A. Acetyl-alpha-methylfentanyl (N/N-(1-(1-methyl-2-phenethyl)-4-piperidinyl)-N/N-phenylacetamide) 9815
- B. Acetylmethadol 9601
- C. Acetyl fentanyl (N-(1-phenethylpiperidin-4-yl)-N-phenylacetamide) 9821

[C./D. AH-7921(3,4-dichloro-[N/N-[(1-dimethylamino)cyclohexylmethyl] benzamide)	9551
[D./E. Allylprodine	9602
[E./F. Alphacetylmethadol (except levoalphacetylmethadol also known as levo-alpha-acetylmethadol levothadyl acetate or LAAM)	9603
[F./G. Alphameprodine	9604
[G./H. Alphamethadol	9605
[H./I. Alpha-methylfentanyl (N/N-1-(alphamethyl-beta-phenyl) ethyl-4-piperidyl) propionanilide; 1-(1-methyl-2-phenylethyl)-4 ((N/N-propanilido) piperidine)	9814
[I./J. Alpha-methylthiofentanyl (N/N-(1-methyl-2-(2-thienyl) ethyl-4-piperidinyl)-N/N-phenylpropanamide)	9832
[J./K. Benzethidine	9606
[K./L. Betacetylmethadol	9607
[L./M. Beta-hydroxyfentanyl (N/N-(1-(2-hydroxy-2-phenethyl)-4-piperidinyl)-N/N-phenylpropanamide)	9830
[M./N. Beta-hydroxy-3-methylfentanyl (Other name: N/N-(1-(2-hydroxy-2-phenethyl)-3-methyl-4-piperidinyl)-N/N-phenylpropanamide)/];	9831
[N./O. Betameprodine	9608
[O./P. Betamethadol	9609
[P./Q. Betaprodine	9611
[Q./R. Clonitazene	9612
[R./S. Dextromoramide	9613
[S./T. Diampromide	9615
[T./U. Diethylthiambutene	9616
[U./V. Difenoxyin	9168
[V./W. Dimenoxadol	9617
[W./X. Dimephtetanol	9618
[X./Y. Dimethylthiambutene	9619
[Y./Z. Dioxaphetyl butyrate	9621
[Z./AA. Dipipanone	9622
[AA./BB. Ethylmethylthiambutene	9623
[BB./CC. Etonitazene	9624
[CC./DD. Etozeridine	9625
[DD./EE. Furethidine	9626
[EE./FF. Hydroxypethidine	9627
[FF./GG. Ketobemidone	9628
[GG./HH. Levomoramide	9629
[HH./II. Levophenacymorphan	9631
[II./JJ. 3-Methylfentanyl (N/N-1-(1-(3-methyl-1-(2-phenylethyl)-4-piperidyl)-N/N-phenylpropanamide), its optical and geometric isomers, salts, and salts of isomers	9813
[JJ./KK. 3-Methylthiofentanyl (N/N-1-(1-(3-methyl-1-(2-thienyl)ethyl-4-piperidinyl)-N/N-phenylpropanamide)	9833
[KK./LL. Morpheridine	9632
[LL./MM. MPPP (1-methyl-4-phenyl-4-propionoxypiperidine)	9661
NN. MT-45 (1-cyclohexyl-4-(1,2-diphenylethyl) piperazine)	(9560)
[MM./OO. Noracymethadol	9633
[NN./PP. Norlevorphanol	9634
[OO./QQ. Normethadone	9635
[PP./RR. Norpipanone	9636
[QQ./SS. Para-fluorofentanyl (N/N-(4-fluorophenyl)-N/N-1-(1-(2-phenethyl)-4-piperidinyl)-propanamide	9812
[RR./TT. PEPAP (1-(2-phenethyl)-4-phenyl-4-acetoxypiperidine)	9663
[SS./UU. Phenadoxone	9637
[TT./VV. Phenampromide	9638
[UU./WW. Phenomorphan	9647

/VV/XX. Phenoperidine	9641
/WW/YY. Piritramide	9642
/XX/ZZ. Proheptazine	9643
/YY/AAA. Properidine	9644
/ZZ/BBB. Propiram	9649
/AAA/CCC. Racemoramide	9645
/BBB/DDD. Thiofentany <i>/[N]-N-phenyl-[N]/N-(1-(2-thienyl)ethyl-4-piperidinyl)-propanamide</i>	9835
/CCC/EEE. Tilidine	9750
/DDD/FFF. Trimeperidine	9646

2. Opium derivatives. Unless specifically excepted or unless listed in another schedule, any of the following opium derivatives, its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

A. Acetorphine	9319
B. Acetyldihydrocodeine	9051
C. Benzylmorphine	9052
D. Codeine methylbromide	9070
E. Codeine-N-Oxide	9053
F. Cyprenorphine	9054
G. Desomorphine	9055
H. Dihydromorphine	9145
I. Drotebanol	9335
J. Etorphine (except hydrochloride salt)	9056
K. Heroin	9200
L. Hydromorphenol	9301
M. Methyldesorphine	9302
N. Methyldihydromorphine	9304
O. Morphine methylbromide	9305
P. Morphine methylsulfonate	9306
Q. Morphine-N-Oxide	9307
R. Myrophine	9308
S. Nicocodeine	9309
T. Nicomorphine	9312
U. Normorphine	9313
V. Pholcodine	9314
W. Thebacon	9315

3. Opiate similar synthetic substances. Substances scheduled by the United States Drug Enforcement Administration as substances that share a pharmacological profile similar to fentanyl, morphine, and other synthetic opioids, unless specifically excepted or unless listed in another schedule. These substances are:

A. Butyryl fentanyl (<i>N</i> -(1-phenethylpiperidin-4-yl)- <i>N</i> -phenylbutyramide)	9822
B. U-47700 (3,4-Dichloro- <i>N</i> -[2-(dimethylamino)cyclohexyl]- <i>N</i> -methyl benzamide)	9547

[3./4. Hallucinogenic substances. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation, which contains any quantity of the following hallucinogenic substances or which contains any of its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation (For purposes of paragraph (1)(A)/3./4. of this rule only, the term isomer includes the optical, position and geometric isomers.):

A. Alpha-ethyltryptamine	7249
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Some trade or other names: etryptamine; Monase; alpha-ethyl-1/*H/H*-indole-3-ethenamine; 3-(2-aminobutyl)indole; alpha-ET; and AET;

B. 4-bromo-2,5-dimethoxyamphetamine	7391
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Some trade or other names: 4-bromo-2, 5-dimethoxy-amethylphenethylamine; 4-bromo-2, 5-DMA;

C. 4-bromo-2,5-dimethoxyphenethylamine	7392
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D. 2,5-dimethoxyamphetamine	7396
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Some trade or other names: 2,5-dimethoxy-amethylphenethylamine; 2,5-DMA;

E. 2,5-dimethoxy-4-ethylamphetamine	7399
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Some trade or other names: DOET;

F. 2,5-dimethoxy-4-(n)-propylthiophenethylamine	7348
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*/[o]*Other name: 2C-T-7//;

G. 2-(2,5-Dimethoxy-4-(n)-propylphenyl) ethanamine (2C-P)	7524
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H. 2-(2,5-Dimethoxy-4-ethylphenyl) ethanamine (2C-E)	7509
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I. 2-(2,5-Dimethoxy-4-methylphenyl) ethanamine (2C-D)	7508
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J. 2-(2,5-Dimethoxy-4-nitro-phenyl) ethanamine (2C-N)	7521
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K. 2-(2,5-Dimethoxyphenyl) ethanamine (2C-H)	7517
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L. 2-(4-Chloro-2,5-dimethoxyphenyl) ethanamine (2C-C)	7519
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M. 2-(4-Ethylthio-2,5-dimethoxyphenyl) ethanamine (2C-T-2)	7385
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N. 2-(4-Iodo-2,5-dimethoxyphenyl) ethanamine (2C-I)	7518
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O. 2-(4-Isopropylthio)-2,5-dimethoxyphenyl) ethanamine (2C-T-4)	7532
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P. 4-methoxyamphetamine	7411
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Some trade or other names: 4-methoxy-amethylphenethylamine; paramethoxyamphetamine; PMA;

Q. 5-methoxy-3,4-methylenedioxyamphetamine	7401
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R. 4-methyl-2,5-dimethoxyamphetamine	7395
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Some trade and other names: 4-methyl-2, 5-dimethoxy-amethylphenethylamine; DOM; and STP;

S. 3,4-methylenedioxyamphetamine	7400
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T. 3,4-methylenedioxymetham-phetamine (MDMA)	7405
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U. 3,4-methylenedioxy- <i>/N/N</i> -ethylamphetamine (also known as <i>/N/N</i> -ethylalpha-methyl-3,4 (methylenedioxy) phenethylamine, <i>/N/N</i> -ethyl MDA, MDE, and MDEA)	7404
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V. <i>N</i> -hydroxy-3,4-methylenedioxyamphetamine (also known as <i>/N/N</i> -hydroxy-alpha-methyl-3,4 (methylenedioxy) phenethylamine and <i>/N/N</i> -hydroxy MDA)	7402
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W. 3,4,5-trimethoxyamphetamine	7390
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X. 5-MeO-DMT or 5-methoxy- <i>/N/N,N,N</i> -dimethyltryptamine	7431
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Y. Alpha-methyltryptamine	7432
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Z. Bufotenine	7433
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Some trade and other names: 3-(b-Dimethylaminoethyl)-5-hydroxy-indole; 3-(2-dimethylaminoethyl)-5-indolol; */N/N,N,N*-dimethylserotonin; 5-hydroxy-*/N/N,N,N*-dimethyltryptamine; map-pine;

AA. Diethyltryptamine	7434
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Some trade and other names: */N/N,N,N*-Diethyltryptamine; DET;

BB. Dimethyltryptamine	7435
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Some trade or other names: DMT;

CC. 5-methoxy- <i>/N/N,N,N</i> -diisopropyltryptamine (other name: 5-MeO-DIPT)	7439
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DD. Ibogaine	7260
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Some trade and other names: 7-Ethyl-6,6β,7,8,9,10,12,13-octahydro-2-methoxy-6, 9-methano-5/*H/H*-pyrido [1',2':1,2] azepino [5,4-b] indole; Tabernanthe iboga;

EE. Lysergic acid diethylamide	7315
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FF. Marihuana	7360
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Some trade or other names: marijuana;

GG. Mescaline	7381
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HH. Parahexyl	7374
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Some trade or other names: 3-Hexyl-1-hydroxy-7,8,9,10-tetrahydro-6,6,9-trimethyl-6/*H/H*-dibenzo[b,d]pyran; Synhexyl;

II. Peyote	7415
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Meaning all parts of the plant presently classified botanically as *Lophophora williamsii* Lemaire, whether growing or not; the seeds thereof; any extract from any part of such plant; and every compound, manufacture, salt, derivative, mixture, or preparation of such plant, its seeds, or extracts;

JJ. <i>/N/N</i> -ethyl-3-piperidyl benzilate	7482
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KK. <i>/N/N</i> -methyl-3-piperidyl benzilate	7484
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LL. Psilocybin	7437
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MM. Psilocyn

7438

NN. Tetrahydrocannabinols naturally contained in a plant of the genus *Cannabis* (*cannabis* 7370 plant), as well as synthetic equivalents of the substances contained in the *cannabis* plant or in the resinous extractives of such plant, and/or synthetic substances, derivatives and their isomers, or both, with similar chemical structure and pharmacological activity to those substances contained in the plant, such as the following:

(I) 1 *cis* or *trans* tetrahydrocannabinol and their optical isomers;

(II) 6 *cis* or *trans* tetrahydrocannabinol and their optical isomers;

(III) 3,4 *cis* or *trans* tetrahydrocannabinol and its optical isomers; and

(IV) Since nomenclature of these substances is not internationally standardized, compounds of these structures, regardless of numerical designation of atomic positions are covered./.;

OO. Ethylamine analog of phencyclidine

7455

Some trade or other names: */N/N*-ethyl-1-phenylcyclohexylamine, (1-phenylcyclohexyl) ethylamine, */N/N*-(1-phenylcyclohexyl)-ethylamine, cyclohexamine, PCE;

PP. Pyrrolidine analog of phencyclidine

7458

Some trade or other names: 1-(1-phenylcyclohexyl)-pyrrolidine PCPy, PHP;

QQ. Thiophene analog of phencyclidine

7470

Some trade or other names: 1-(1-(2-thienyl)-cyclohexyl)-piperidine, 2-thienyl analog of phencyclidine, TPCP, TCP;

RR. 1-(1-(2-thienyl)cyclohexyl) pyrrolidine

7473

Some other names: TCPy./.;

SS. *Salvia divinorum*;

TT. Salvinorin A;

UU. Synthetic cannabinoids: Unless specifically exempted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances, or which contains their salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

(I) Any compound structurally derived from 3-(1-naphthoyl)indole or 1-*H/H*-indol-3-yl-(1-naphthyl)methane by substitution at the nitrogen atom of the indole ring by alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(*/N/N*-methyl-2-piperidinyl)methyl, or 2-(4-morpholinyl)ethyl group, whether or not further substituted in the indole ring to any extent, whether or not substituted in the naphthyl ring to any extent. Including, but not limited to:

- (a) AM2201, or 1-(5-fluoropentyl)-3-(1-naphthoyl)indole 7201
- (b) JWH-007, or 1-pentyl-2-methyl-3-(1-naphthoyl)indole
- (c) JWH-015, or 1-propyl-2-methyl-3-(1-naphthoyl)indole
- (d) JWH-018, or 1-pentyl-3-(1-naphthoyl)indole 7118
- (e) JWH-019, or 1-hexyl-3-(1-naphthoyl)indole 7019
- (f) JWH-073, or 1-butyl-3-(1-naphthoyl)indole 7173
- (g) JWH-081, or 1-pentyl-3-(4-methoxy-1-naphthoyl)indole 7081
- (h) JWH-098, or 1-pentyl-2-methyl-3-(4-methoxy-1-naphthoyl)indole
- (i) JWH-122, or 1-pentyl-3-(4-methyl-1-naphthoyl)indole 7122
- (j) JWH-164, or 1-pentyl-3-(7-methoxy-1-naphthoyl)indole
- (k) JWH-200, or 1-(2-(4-(morpholinyl)ethyl))-3-(1-naphthoyl)indole 7200
- (l) JWH-210, or 1-pentyl-3-(4-ethyl-1-naphthoyl)indole
- (m) JWH-398, or 1-pentyl-3-(4-chloro-1-naphthoyl)indole 7398

(II) Any compound structurally derived from 3-(1-naph-

thoyl)pyrrole by substitution at the nitrogen atom of the pyrrole ring by alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(*/N/N*-methyl-2-piperidinyl)methyl, or 2-(4-morpholinyl)ethyl group, whether or not further substituted in the pyrrole ring to any extent, whether or not substituted in the naphthyl ring to any extent;

(III) Any compound structurally derived from 1-(1-naphthylmethyl)indene by substitution at the 3-position of the indene ring by alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(*/N/N*-methyl-2-piperidinyl)methyl, or 2-(4-morpholinyl)ethyl group, whether or not further substituted in the indene ring to any extent, whether or not substituted in the naphthyl ring to any extent;

(IV) Any compound structurally derived from 3-phenylacetylindole by substitution at the nitrogen atom of the indole ring with alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(*/N/N*-methyl-2-piperidinyl)methyl, or 2-(4-morpholinyl)ethyl group, whether or not further substituted in the indole ring to any extent, whether or not substituted in the phenyl ring to any extent. Including, but not limited to:

- (a) JWH-201, or 1-pentyl-3-(4-methoxyphenylacetyl)indole
- (b) JWH-203, or 1-pentyl-3-(2-chlorophenylacetyl)indole 7203
- (c) JWH-250, or 1-pentyl-3-(2-methoxyphenylacetyl)indole 6250
- (d) JWH-251, or 1-pentyl-3-(2-methylphenylacetyl)indole
- (e) RCS-8, or 1-(2-cyclohexylethyl)-3-(2-methoxyphenylacetyl)indole 7008

(V) Any compound structurally derived from 2-(3-hydroxycyclohexyl)phenol by substitution at the 5-position of the phenolic ring by alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(*/N/N*-methyl-2-piperidinyl)methyl, or 2-(4-morpholinyl)ethyl group, whether or not substituted in the cyclohexyl ring to any extent. Including, but not limited to:

(a) CP 47,497 & homologues, or 2-[(1R,3S)-3-hydroxycyclohexyl]-5-(2-methyloctan-2-yl)phenol, where side chain n=5, and homologues where side chain n=4,6, or 7; 7297, 7298

(VI) Any compound containing a 3-(benzoyl)indole structure with substitution at the nitrogen atom of the indole ring by alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(*/N/N*-methyl-2-piperidinyl)methyl, or 2-(4-morpholinyl)ethyl group, whether or not further substituted in the indole ring to any extent and whether or not substituted in the phenyl ring to any extent. Including, but not limited to:

- (a) AM-694, or 1-(5-fluoropentyl)-3-(2-iodobenzoyl)indole 7694
- (b) RCS-4, or 1-pentyl-3-(4-methoxybenzoyl)indole (SR-19 and RCS-4) 7104

(VII) CP 50,556-1, or [(6S,6aR,9R,10aR)-9-hydroxy-6-methyl-3-[(2R)-5-phenylpentan-2-yl]oxy-5,6,6a,7,8,9,10,10a-octahydrophenanthridin-1-yl] acetate;

(VIII) HU-210, or (6aR,10aR)-9-(hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl)-6a,7,10,10a-tetrahydrobenzo[c]chromen-1-ol;

(IX) HU-211, or Dexanabinol, (6aS,10aS)-9-(hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl)-6a,7,10,10a-tetrahydrobenzo[c]chromen-1-ol; **and**

(X) Dimethylheptylpyran, or DMHP.

/4./5. Depressants. Unless specifically excepted or unless listed in another schedule, any material compound, mixture, or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system, including its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

A. Gamma-hydroxybutyric acid and other names GHB; gamma-hydroxybutyrate; 4-hydroxybutyrate; 4-hydroxybutonic acid; sodium oxybate; sodium oxybutyrate; 2010

B. Mecloqualone 2572

C. Methaqualone	2565	(Other names: 25I-NBOMe; 2C-I-NBOMe; 25I; Cimbi-5)	7538	
[5./6. Stimulants. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system, including its salts, isomers, and salts of isomers:				
A. Aminorex	1585	E. 2-(4-chloro-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 25C-NBOMe; 2C-C-NBOMe; 25C; Cimbi-82)	7537	
Some trade or other names: aminoxaphen; 2-amino-5-phenyl-2-oxazoline; 4,5-dihydro-5-phenyl-2-oxazolamine;		F. 2-(4-bromo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 25B-NBOMe; 2C-B-NBOMe; 25B; Cimbi-36)	7536	
B. /N/N-benzylpiperazine	7493	G. 4-methyl-N-ethylcathinone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 4-MEC; 2-(ethylamino)-1-(4-methylphenyl)propan-1-one)	1249	
[s/Some other names: BZP, 1-benzylpiperzaine];				
C. Cathinone	1235	H. 4-methyl- <i>alpha</i> -pyrrolidinopropiophenone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 4-MePPP; MePPP; 4-methyl- <i>alpha</i> -pyrrolidinopropiophenone; 1-(4-methylphenyl)-2-(pyrrolidin-1-yl)-propan-1-one)	7498	
[Some trade or other names: 2-amino-1-phenyl-1-propanone, alphaaminopropiophenone, 2-aminopropiophenone and norephedrone];				
D. Fenethylline	1503	I. <i>alpha</i> -pyrrolidinopentiophenone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: <i>alpha</i> -PVP; <i>alpha</i> -pyrrolidinovalerophenone; 1-phenyl-2-(pyrrolidin-1-yl)pentan-1-one)	7545	
E. 3-Fluoromethcathinone	1233	J. Butylone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: bk-MBDB; 1-(1,3-benzodioxol-5-yl)-2-(methylamino)butan-1-one)	7541	
F. 4-Fluoromethcathinone	1238	K. Pentedrone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: <i>alpha</i> -methylaminovalerophenone; 2-(methylamino)-1-phenylpentan-1-one)	1246	
G. Mephedrone, or 4-methylmethcathinone	1248	L. Pentylone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: bk-MBDP; 1-(1,3-benzodioxol-5-yl)-2-(methylamino)pentan-1-one)	7542	
H. Methcathinone	1237	M. Naphyrone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: naphthylpyrovalerone; 1-(naphthalen-2-yl)-2-(pyrrolidin-1-yl)pentan-1-one)	1258	
Some trade or other names: 2-(methylamino)-propiophenone; alpha-(methylamino) propiophenone; 2-(methylamino)-1-phenylpropan-1-one; alpha-/N/N-methylaminopropiophenone; monomethylpropion; ephedrone; /N/N-methylcathinone; methylcathinine; AL-464; AL-422; AL-463; and URI 432;		N. <i>alpha</i> -pyrrolidinobutiophenone, its optical, positional, and geometric isomers (Other names: <i>alpha</i> -PBP; 1-phenyl-2-(pyrrolidin-1-yl)butan-1-one)	7546	
I. 4-methoxymethcathinone		O. N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(cyclohexylmethyl)-1H-indazole-3-carboxamide, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: AB-CHMINACA)	7031	
J. cis-4-methylaminorex (cis-4,5-dihydro-4-methyl-5-phenyl-2-oxazolamine)	1590	P. N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-pentyl-1H-indazole-3-carboxamide, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: AB-PINACA)	7023	
K. Methylenedioxypyrovalerone, MDPV, or (1-(1,3-Benzodioxol-5-yl)-2-(1-pyrrolidinyl)-1-pentanone	7535	Q. [1-(5-fluoropentyl)-1H-indazol-3-yl](naphthalen-1-yl)methanone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: THJ-2201)	7024	
L. Methylone, or 3,4-Methylenedioxymethcathinone	7540	[R. N-(1-phenethylpiperidin-4-yl)-N-phenylbutyramide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other names: butyryl fentanyl)]		9822]
M. 4-Methyl-alpha-pyrrolidinobutiophenone, or MPBP		[S./R. N-[1-[2-hydroxy-2-(thiophen-2-yl)ethyl]piperidin-4-yl]-N-phenylpropionamide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other names: beta-hydroxythiofentanyl)]		9836
N. /N/N-ethylamphetamine	1475			
O. /N/N,N-dimethylamphetamine	1480			
[s/Some other names: /N/N,N,N-alpha-trimethylbenzeneethanamine; N,N-alpha-trimethylphenethylamine];				
P. Quinolin-8-yl 1-pentyl-1H-indole-3-carboxylate (PB-22; QUPIC)	7222			
Q. Quinolin-8-yl 1-(5-fluoropentyl)-1H-indole-3-carboxylate (5-fluoro-PB-22; 5F-PB-22)	7225			
R. N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(4-fluorobenzyl)-1H-indazole-3-carboxamide (AB-FUBINACA)	7012			
S. N-(1-amino-3, 3-dimethyl-1-oxobutan-2-yl)-1-pentyl-1H-indazole-3-carboxamide (ADB-PINACA)	7035			
[6./7. A temporary listing of substances subject to emergency scheduling under federal law shall include any material, compound, mixture, or preparation which contains any quantity of the following substances:				
A. (1-pentyl-1H-indol-3-yl)(2,2,3,3-tetramethylcyclopropyl) methanone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: UR-144, 1-pentyl-3-(2,2,3,3-tetramethylcyclopropyl)indole)	7144			
B. [1-(5-fluoro-pentyl)-1H-indol-3-yl](2,2,3,3-tetramethylcyclopropyl) methanone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 5-fluoro-UR-144, 5-F-UR-144, XLR11, 1-(5-fluoro-pentyl)-3-(2,2,3,3-tetramethylcyclopropyl)indole)	7011			
C. N-(1-adamantyl)-1-pentyl-1H-indazole-3-carboxamide, its optical, positional, and geometric isomers, salts, and salts of isomer (Other names: APINACA, AKB48)	7048			
D. 2-(4-iodo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine, its optical, positional, and geometric isomers, salts, and salts of isomers				

- [T./S. *N*-(1-phenethylpiperidin-4-yl)-*N*-phenylacetamide, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: acetyl fentanyl) 9821
- [U./T. *N*-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1-(cyclohexylmethyl)-1*H*-indazole-3-carboxamide, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: MAB-CHMINACA; ADB-CHMINACA) 7032
- [V. 3, 4-dichloro-*N*-[2-(dimethylamino)cyclohexyl]-*N*-methylbenzamide (Other names: U-47700) 9547]
- [W./U. *N*-(1-phenethylpiperidin-4-yl)-*N*-phenylfuran-2-carboxamide (Other names: furanyl fentanyl) 9834
- V. methyl 2-(1-(5-fluoropentyl)-1*H*-indazole-3-carboxamido)-3,3-dimethylbutanoate, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 5F-ADB; 5F-MDMB-PINACA) (7034)
- W. methyl 2-(1-(5-fluoropentyl)-1*H*-indazole-3-carboxamido)-3-methylbutanoate, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 5F-AMB) (7033)
- X. *N*-(adamantan-1-yl)-1-(5-fluoropentyl)-1*H*-indazole-3-carboxamide, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 5F-APINACA, 5F-AKB48) (7049)
- Y. *N*-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1-(4-fluorobenzyl)-1*H*-indazole-3-carboxamide, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: ADB-FUBINACA) (7010)
- Z. methyl 2-(1-(cyclohexylmethyl)-1*H*-indole-3-carboxamido)-3,3-dimethylbutanoate, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: MDMB-CHMICA, MMB-CHMINACA) (7042)
- AA. methyl 2-(1-(4-fluorobenzyl)-1*H*-indazole-3-carboxamido)-3,3-dimethylbutanoate, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: MDMB-FUBINACA) (7020)
- BB. *N*-(4-fluorophenyl)-*N*-(1-phenethylpiperidin-4-yl)isobutyramide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other names: 4-fluoroisobutyryl fentanyl, *para*-fluoroisobutyryl fentanyl) (9824)
- CC. *N*-(1-phenethylpiperidin-4-yl)-*N*-phenylacrylamide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other names: acryl fentanyl, acryloylfentanyl) (9811)
- DD. *N*-(2-fluorophenyl)-*N*-(1-phenethylpiperidin-4-yl)propionamide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other names: *ortho*-fluorofentanyl, 2-fluorofentanyl) (9816)
- EE. *N*-(1-phenethylpiperidin-4-yl)-*N*-phenyltetrahydrofuran-2-carboxamide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other name: tetrahydrofuran fentanyl) (9843)
- FF. 2-methoxy-*N*-(1-phenethylpiperidin-4-yl)-*N*-phenylacetamide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other name: methoxyacetyl fentanyl) (9825)
- GG. methyl 2-(1-(4-fluorobenzyl)-1*H*-indazole-3-carboxamido)-3-methylbutanoate, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: FUB-AMB, MMB-FUBINACA, AMB-FUBINACA) (7021)
- HH. *N*-(1-phenethylpiperidin-4-yl)-*N*-phenylcyclopropanecarboxamide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other name: cyclopropyl fentanyl) (9845)
- II. *N*-(1-phenethylpiperidin-4-yl)-*N*-phenylpentanamide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other name: valeryl fentanyl) (9804)
- JJ. *N*-(4-fluorophenyl)-*N*-(1-phenethylpiperidin-4-yl) butyramide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other name: *para*-fluorobutyryl fentanyl) (9823)
- KK. *N*-(4-methoxyphenyl)-*N*-(1-phenethylpiperidin-4-yl)butyramide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other name: *para*-methoxybutyryl fentanyl) (9837)
- LL. *N*-(4-chlorophenyl)-*N*-(1-phenethylpiperidin-4-yl)isobutyramide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other name: *para*-chloroisobutyryl fentanyl) (9826)
- MM. *N*-(1-phenethylpiperidin-4-yl)-*N*-phenylisobutyramide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other name: isobutyryl fentanyl) (9827)
- NN. *N*-(1-phenethylpiperidin-4-yl)-*N*-phenylcyclopentanecarboxamide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other name: cyclopentyl fentanyl) (9847)
- OO. *N*-(2-fluorophenyl)-2-methoxy-*N*-(1-phenethylpiperidin-4-yl)acetamide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other name: oc fentanyl) (9832)
- PP. Fentanyl-related substances, their isomers, esters, ethers, salts, and salts of isomers, esters, and ethers. 9850
- (I) Fentanyl-related substance means any substance not otherwise listed under another Administration Controlled Substance Code Number, and for which no exemption or approval is in effect under section 505 of the Federal Food, Drug, and Cosmetic Act 21 U.S.C. 355, that is structurally related to fentanyl by one or more of the following modifications:
- (a) Replacement of the phenyl portion of the phenethyl group by any monocycle, whether or not further substituted in or on the monocycle;
- (b) Substitution in or on the phenethyl group with alkyl, alkenyl, alkoxyl, hydroxyl, halo, haloalkyl, amino, or nitro groups;
- (c) Substitution in or on the piperidine ring with alkyl, alkenyl, alkoxyl, ester, ether, hydroxyl, halo, haloalkyl, amino, or nitro groups;
- (d) Replacement of the aniline ring with any aromatic monocycle whether or not further substituted in or on the aromatic monocycle; and/or
- (e) Replacement of the *N*-propionyl group by another acyl group;
- QQ. Naphthalen-1-yl 1-(5-fluoropentyl)-1*H*-indole-3-carboxylate, its optical, positional, and geometric isomers, salts, and salts of isomers

- (Other names: NM2201; CBL2201) (7221)
RR. *N*-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(5-fluoropentyl)-1*H*-indazole-3-carboxamide, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 5F-AB-PINACA) (7025)
SS. 1-(4-cyanobutyl)-*N*-(2-phenylpropan-2-yl)-1*H*-indazole-3-carboxamide, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 4-CN-CUMYL-BUTINACA; 4-cyano-CUMYL-BUTINACA; 4-CN-CUMYLBINACA; CUMYL-4CN-BINACA; SGT-78) (7089)
TT. methyl 2-(1-(cyclohexylmethyl)-1*H*-indole-3-carboxamido)-3-methylbutanoate, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: MMB-CHMICA, AMB-CHMICA) (7044)
UU. 1-(5-fluoropentyl)-*N*-(2-phenylpropan-2-yl)-1*H*-pyrrolo[2,3-*b*]pyridine-3-carboxamide, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 5F-CUMYL-P7AICA) (7085)
VV. *N*-Ethylpentylone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: ephylone, 1-(1,3-benzodioxol-5-yl)-2-(ethylamino)-pentan-1-one) (7543)

[7.78. Khat, to include all parts of the plant presently classified botanically as *catha edulis*, whether growing or not; the seeds thereof; any extract from any part of such plant; and every compound, manufacture, salt, derivative, mixture, or preparation of the plant, its seed, or extracts. 7032

(B) Schedule II shall consist of the drugs and other substances, by whatever official name, common or usual name, chemical name, or brand name designated, listed in this section. Each drug or substance has been assigned the Controlled Substances Code Number set forth opposite it.

1. Substances, vegetable origin, or chemical synthesis. Unless specifically excepted or unless listed in another schedule, Schedule II shall include any of the following substances whether produced directly or indirectly by extraction from substances of vegetable origin or independently by means of chemical synthesis or by a combination of extraction and chemical synthesis:

A. Opium and opiate; and any salt, compound, derivative, or preparation of opium or opiate, excluding apomorphine, thebaine-derived butorphanol, dextrophan, nalbuphine, nalmefene, naloxegol, naloxone, and naltrexone and their respective salts, but including the following:

(I) Raw opium	9600
(II) Opium extracts	9610
(III) Opium fluid	9620
(IV) Powdered opium	9639
(V) Granulated opium	9640
(VI) Tincture of opium	9630
(VII) Codeine	9050
(VIII) Dihydroetorphine	9334
(IX) Ethylmorphine	9190
(X) Etorphine hydrochloride	9059
(XI) Hydrocodone	9193
(XII) Hydromorphone	9150
(XIII) Metopon	9260
(XIV) Morphine	9300
(XV) Oripavine	9330
(XVI) Oxycodone	9143
(XVII) Oxymorphone	9652
(XVIII) Thebaine	9333

B. Any salt, compound, derivative, or preparation thereof which is chemically equivalent or identical with any of the substances referred to in subparagraph (1)(B)1.A. of this rule shall be included

in Schedule II, except that these substances shall not include the isoquinoline alkaloids of opium;

C. Opium poppy and poppy straw[;] 9650

D. Coca leaves (9040) and any salt, compound, derivative, or preparation of coca leaves (including cocaine (9041) and ecgonine (9180) and their salts, isomers, derivatives, and salts of isomers and derivatives), and any salt, compound, derivative, or preparation thereof which is chemically equivalent or identical with any of these substances, except that the substances shall not include:

(I) Decocainized coca leaves or extraction of coca leaves, which extractions do not contain cocaine or ecgonine; or

(II) Ioflupane[.];

E. Concentrate of poppy straw (the crude extract of poppy straw in either liquid, solid, or powder form which contains the phenanthrene alkaloids of the opium poppy) 9670

2. Opiates. Unless specifically excepted or unless in another schedule any of the following opiates, including its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers whenever the existence of such isomers, esters, ethers, and salts is possible within the specific chemical designation, dextrophan, and levopropoxyphene excepted:

A. Alfentanil	9737
B. Alphaprodine	9010
C. Anileridine	9020
D. Bezitramide	9800
E. Bulk Dextropropoxyphene (Non-dosage Forms)	9273
F. Carfentanil	9743
G. Dihydrocodeine	9120
H. Diphenoxylate	9170
I. Fentanyl	9801
J. Isomethadone	9226
K. Levo-alphaacetylmethadol	9220

Some other names: levo-alphaacetylmethadol, levomethadyl acetate, LAAM 9648

L. Levomethorphan	9210
M. Levorphanol	9220
N. Metazocine	9240
O. Methadone	9250
P. Methadone-Intermediate, 4-cyano-2-dimethylamino-4,4-diphenyl butane	9254
Q. Moramide-Intermediate, 2-methyl-3-morpholino-1,1-diphenylpropane-carboxylic acid	9802
R. Pethidine (Meperidine)	9230
S. Pethidine-Intermediate-A, 4-cyano-1-methyl-4-phenylpiperidine	9232
T. Pethidine-Intermediate-B, ethyl-4-phenylpiperidine-4-carboxylate	9233
U. Pethidine-Intermediate-C, 1-methyl-4-phenylpiperidine-4-carboxylic acid	9234
V. Phenazocine	9715
W. Piminodine	9730
X. Racemethorphan	9732
Y. Racemorphan	9733
Z. Remifentanil	9739
AA. Sufentanil	9740
BB. Tapentadol	9780
CC. Thiafentanil	9729

3. Stimulants. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system:

A. Amphetamine, its salts, optical isomers, and salts of its optical isomers	1100
B. Lisdexamphetamine, its salts, isomers, and salts of its isomers	1205
C. Methamphetamine, its salts, isomers, and salts of its isomers	1105
D. Phenmetrazine and its salts	1631
E. Methylphenidate	1724

4. Depressants. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system, including its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

A. Amobarbital	2125
B. Glutethimide	2550
C. Pentobarbital	2270
D. Phencyclidine	7471
E. Secobarbital	2315

5. Hallucinogenic substances:

A. Nabilone	7379
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Another name for nabilone: (\pm)trans-3-(1, 1-dimethylheptyl)-6, 6a,7,8,10,10a-hexahydro-1-hydroxy-6, 6-dimethyl-9H-dibenzo(b,d)pyran-9-one.

B. Dronabinol [(\pm)-delta-9-trans tetrahydrocannabinol] in an oral solution in a drug product approved for marketing by the United States Food and Drug Administration. (7365)

6. Immediate precursors. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances:

A. Immediate precursor to amphetamine and methamphetamine:

(I) Phenylacetone	8501
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Some trade or other names: phenyl-2- propanone; P2P; benzyl methyl ketone; methyl benzyl ketone;

B. Immediate precursors to phencyclidine (PCP):

(I) 1-phenylcyclohexylamine	7460
(II) 1-piperidinocyclo-hexanecarbonitrile (PCC)	8603

C. Immediate precursor to fentanyl:

(I) 4-anilino-N-phenethyl-4-piperidine (ANPP)	8333
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7. Any material, compound, mixture, or preparation which contains any quantity of the following alkyl nitrites:

- A. Amyl nitrite;
- B. Butyl nitrite.

(E) Schedule V shall consist of the drugs and other substances, by whatever official name, common or usual name, chemical name, or brand name designated, listed in this subsection.

1. Narcotic drugs containing nonnarcotic active medicinal ingredients. Any compound, mixture, or preparation containing any of the following narcotic drugs, or their salts calculated as the free anhydrous base or alkaloid, in limited quantities as follows, which shall include one (1) or more nonnarcotic active medicinal ingredients in sufficient proportion to confer upon the compound, mixture, or preparation valuable medicinal qualities other than those possessed by the narcotic drug alone:

A. Not more than two hundred milligrams (200 mg) of codeine per one hundred milliliters (100 mL) or per one hundred grams (100 g);

B. Not more than one hundred milligrams (100 mg) of dihydrocodeine per one hundred milliliters (100 mL) or per one hundred grams (100 g);

C. Not more than one hundred milligrams (100 mg) of ethylmorphine per one hundred milliliters (100 mL) or per one hundred grams (100 g)/.;

D. Not more than two and five-tenths milligrams (2.5 mg) of diphenoxylate and not less than twenty-five micrograms (25 mcg) of atropine sulfate per dosage unit/.;

E. Not more than one hundred milligrams (100 mg) of opium per one hundred milliliters (100 mL) or per one hundred grams (100 g)/.; and

F. Not more than five-tenths milligram (0.5 mg) of difenoxin (DEA Drug Code No. 9168) and not less than twenty-five micrograms (25 mcg) of atropine sulfate per dosage unit.

2. Stimulants. Unless specifically exempted or excluded or unless listed in another schedule, any material, compound, mixture,

or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system including its salts, isomers, and salts of isomers:

A. Pyrovalerone 1485

3. Any compound, mixture, or preparation containing any detectable quantity of pseudoephedrine or its salts or optical isomers, or salts of optical isomers or any compound, mixture, or preparation containing any detectable quantity of ephedrine or its salts or optical isomers, or salts of optical isomers if the drug preparations are starch-based solid dose forms, if such preparations are sold over the counter without a prescription. The following drug preparations containing ephedrine and pseudoephedrine are not scheduled controlled substances:

A. Drug preparations in liquid form;

B. Drug preparations that require a prescription in order to be dispensed.

4. Unless specifically exempted or excluded or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system, including its salts:

A. Ezogabine [*N*-[2-amino-4-(4- fluorobenzylamino)-phenyl]-carbamic acid ethyl ester] 2779

B. Lacosamide [(*R*)-2-acetoamido-*N*-benzyl-3-methoxy-propionamide] 2746

C. Pregabalin [(*S*)-3-(aminomethyl)-5-methylhexanoic acid] 2782

D. Brivaracetam ((2*S*)-2-[(4*R*)-2-oxo-4-propylpyrrolidin-1-yl]butanamide) (also referred to as BRV; UCB-34714; Briviact) 2710

5. Approved cannabidiol drugs.

A. A drug product in finished dosage formulation that has been approved by the U.S. Food and Drug Administration that contains cannabidiol (2-[1*R*-3-methyl-6*R*-(1-methylethenyl)-2-cyclohexen-1-yl]-5-pentyl-1,3-benzenediol) derived from cannabis and no more than one tenth percent (0.1%) (w/w) residual tetrahydrocannabinols 7367

AUTHORITY: sections 195.015 and 195.195, RSMo 2016. Material found in this rule previously filed as 19 CSR 30-1.010. Original rule filed April 14, 2000, effective Nov. 30, 2000. Amended: Filed Jan. 31, 2003, effective July 30, 2003. Amended: Filed Sept. 30, 2016, effective May 30, 2017. Emergency amendment filed Oct. 25, 2018, effective Nov. 4, 2018, expires May 2, 2019. A proposed amendment covering this same material is published in this issue of the Missouri Register.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 1—General Organization**

EMERGENCY RULE

22 CSR 10-1.030 Board of Trustees Election Process

PURPOSE: This rule establishes the policy of the board of trustees in regard to election of board members by the subscribers of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency rule is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of

confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule to maintain the integrity of the current health care plan. This emergency rule fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the Missouri Register. This emergency rule complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.

(1) The subscribers of the Missouri Consolidated Health Care Plan (MCHCP) shall elect two (2) active employee members and one (1) retiree member to the board of trustees. Each member will serve a term of four (4) years from the first day of January following their election.

(2) Board Member Candidate Eligibility.

(A) Candidates must be a subscriber of the plan.

(B) A candidate who is running for a position on the board as an active employee member must be employed on the date the nominating petitions are due. Failure to be employed at that time will result in an automatic disqualification.

(C) A candidate who is running for a position on the board as a retiree member must be retired on the date that the nominating petitions are due. Failure to be retired at that time will result in an automatic disqualification.

(D) The following members are not eligible candidates:

1. Current employees of the plan;

2. Immediate relatives of persons employed by the plan.

Immediate relatives include:

A. Employee's spouse;

B. Children of employee or spouse;

C. Parents of employee or spouse;

D. Brothers and sisters of employee, including brothers-in-law and sisters-in-law;

E. Grandchildren (including great-grandchildren) of employee or spouse;

F. Grandparents (including great-grandparents) of employee or spouse; and

G. Members of the employee's household.

(E) It will be automatic grounds for disqualification if it is determined that a candidate knowingly submitted false information in the election process.

(3) Nomination Process.

(A) Candidates will be nominated by means of a nominating petition.

(B) The plan will notify subscribers of an opening for a board position.

(C) Candidates may only run for one (1) position on the board.

(D) Candidates must download from MCHCP's website, complete, and submit in a manner indicated by the plan, a valid nominating petition by a date determined by the plan. Valid nominating petitions include:

1. Candidate Information, including but not limited to, name, department, and resume;

2. Information to solicit the candidate's interest in health care issues;

3. Information to solicit any disqualifying information of the candidate;

4. A summary of information regarding the candidate's background and qualifications, for example: years of state service, department experience, and reasons for wanting to be on the board. The summary shall not exceed three hundred (300) words and will be used on the voting website. Formatting of this information for the board election ballot materials will be under the direction of the plan; and

5. Any additional information as determined by the plan which is important to the nominating and voting process.

(E) Board member candidates may not use state resources (equipment, personnel, and supplies) for campaign purposes. Board member candidates may not use interagency mail or send email from a computer provided by the state to distribute campaign materials. State agencies, at their discretion, may allow the posting of campaign materials provided by the candidates on an equal time basis.

(F) Board candidates may not use the plan's resources for campaign purposes. This includes receiving demographic information of the plan's members, including but not limited to, member names, phone numbers, addresses, and email addresses.

(G) The plan will establish procedures to ensure candidate information is true and accurate. These procedures will include, but may not be limited to, validation of the information on the candidate petition forms.

(H) If only one (1) valid nominating petition is filed for any vacancy, the person nominated will be declared elected by the board at the next regular board meeting.

(I) If at least one (1) valid nominating petition is not filed for each vacancy to be filled, this election process shall be repeated for that vacancy until a valid nominating petition is received.

(4) Election Ballots and Results.

(A) The plan will notify members of an election voting period in advance of the start of the voting period in the year of the board election.

(B) The voting period will be at least fourteen (14) calendar days in length. The beginning date of the voting period will be set by MCHCP's Executive Director.

(C) Voters must be a subscriber of the plan as of the last day of the month preceding the month in which the election is to be held.

(D) Names of candidates will be listed on the website or in a supplemental publication in random order at the discretion of the plan. In no event will names of candidates be placed in alphabetical order on the election ballot or in a supplemental publication other than by happenstance.

(E) All board election voting will be completed through the eligible subscriber's myMCHCP account. Access to computers for voting use will be available at MCHCP during normal business hours. Ballots not submitted through a myMCHCP account are invalid. An eligible subscriber may only vote once per election.

(F) Voting will cease at midnight Missouri time on the last day of the board election.

(G) Ballots for an active employee member election will allow selection of one (1) or two (2) active employee member candidates to become board members depending on the number of positions up for election. If the election is for two (2) board positions, the two (2) candidates receiving the highest number of votes will be declared elected. If the election is for one (1) board position, the candidate receiving the highest number of votes will be declared elected. If a tie occurs between two (2) or more candidates receiving an identical number of votes, the winner shall be determined by a toss of a coin.

(H) Ballots for retiree members will allow selection for one (1) retiree member candidate to become a board member. The one (1) candidate receiving the highest number of votes will be declared

elected. If a tie occurs between two (2) or more candidates receiving an identical number of votes, the winner shall be determined by a toss of a coin.

(I) The Executive Director will administer any online balloting procedures, record all votes, and declare election results.

(J) The election results will be posted within forty-eight (48) hours of the official certification of the election by the plan. Voting records will be maintained by the Executive Director for a period of one (1) year. After one (1) year from the date of the certification of the results, voting information will be destroyed.

(K) Newly elected board members will begin their terms upon certification of the election.

(5) Qualifications for Board Members.

(A) The winning candidate(s) shall file a personal financial disclosure per RSMo, 103.008 within thirty (30) days of their election to the board.

(B) A board member representing active employee members must be employed on January 1 of each year following the election. Failure to be employed at that time will result in their resignation from the board.

(C) A board member representing active employee members who terminates employment with a covered agency for more than thirty (30) consecutive days while serving on the board will be considered to have resigned from the board. The election process will begin to fill the vacant seat within ninety (90) days of the resignation.

(D) A candidate who is running for a position on the board as a retiree member must be retired on January 1 of each year following the election. Failure to be retired at that time will result in an automatic disqualification.

(E) A retiree board member who becomes employed in a MCHCP benefit eligible position while serving on the board will be considered to have resigned from the board. The election process will begin to fill the vacant seat within ninety (90) days of the resignation.

(6) Vacancies. If a vacancy occurs at any time in the three (3) elected seats, election procedures will begin to take place within ninety (90) days of the vacancy.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed rule covering this same material is published in this issue of the Missouri Register.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

EMERGENCY AMENDMENT

22 CSR 10-2.010 Definitions. The Missouri Consolidated Health Care Plan is amending sections (19), (29), (39), (51) and (52), deleting section (74), and renumbering thereafter.

PURPOSE: This amendment revises the definitions of diabetes education, essential benefits, Health Savings Account Plan, network, and non-network; removes the definition of terminated vested subscriber because it is duplicative of section (79); and renumbers as necessary.

PURPOSE: This rule establishes the policy of the board of trustees in regard to the definitions of the Missouri Consolidated Health Care Plan relative to state members.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2019, in accordance with the new plan year.

Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.

(19) Diabetes [Education] self-management/training. A program prescribed by a provider and taught by a Certified Diabetes Educator to educate and support members with diabetes.

(29) Essential benefits. The plan covers essential benefits as required by the Patient Protection and Affordable Care Act. Essential benefits include:

(J) Pediatric services, including oral and vision care—routine vision exam, dental care/accidental injury, [immunizations] vaccinations, preventive services, and newborn screenings.

(39) [Health Savings Account (HSA)] High Deductible Health Plan. A health plan with a higher deductible than a traditional health plan that, when combined with an HSA, provides a tax-advantaged way to help save for future medical expenses.

(51) Network. The [facilities,] providers, [and suppliers] the health insurer, or plan has contracted with to provide health care services to members.

(52) Non-network. The [facilities,] providers, [and suppliers] the health insurer, or plan does not contract with to provide health care services to members. Some providers may be a part of secondary provider networks recognized by the vendor for non-network benefits.

[[74] Terminated vested subscriber. A previous active employee eligible for a future retirement benefit from MOSERS, MPERS, or grandfathered for coverage under the plan by law.]

[[75]](74) Termination of coverage. The termination of medical, dental, or vision coverage initiated by the employer or required by MCHCP eligibility policies.

[[76]](75) Tobacco. Cigarettes, cigarette papers, clove cigarettes, cigars, smokeless tobacco, smoking tobacco, other form of tobacco products, or products made with tobacco substitute containing nicotine.

[(77)](76) Tobacco-free. A member has not used a tobacco product in at least the previous three (3) months and plans to remain tobacco-free in the future.

[(78)](77) Usual, customary, and reasonable. The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service.

[(79)](78) Vendor. The current applicable third-party administrators of MCHCP benefits or other services.

[(80)](79) Vested subscriber. An active employee eligible for coverage under the plan and eligible for future benefits from MOSERS, MPERS, or grandfathered for coverage under the plan by law.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed amendment covering this same material is published in this issue of the Missouri Register.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.020 General Membership Provisions. The Missouri Consolidated Health Care Plan is amending sections (2), (3), (5), (8), and (9).

PURPOSE: This amendment revises eligibility requirements, enrollment procedures, voluntary cancellation of coverage requirements, enrollment of a newborn child proof of eligibility procedures, disabled dependent documentation timeframes, leave of absence form, and payment timeframes.

PURPOSE: This rule establishes the policy of the board of trustees in regard to the general membership provisions of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan

Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.

(2) Eligibility Requirements.

(B) Retiree Coverage.

1. An employee may participate in an MCHCP plan when s/he retires if s/he receives a monthly retirement benefit from either MOSERS or from Public School Retirement System (PSRS) for state employment. The employee may elect coverage for him/herself and his/her spouse/child(ren), provided the employee and his/her spouse/child(ren) have been continuously covered for health care benefits—

A. Through MCHCP since the effective date of the last open enrollment period;

B. Through MCHCP since the initial date of eligibility; or

C. Through group or individual medical coverage for the six (6) months immediately prior to retirement. Proof of prior group or individual coverage (letter from previous insurance carrier or former employer with dates of effective coverage and list of persons covered) is required.

2. An employee may enroll him/herself and his/her spouse/child(ren) in an MCHCP dental and/or vision plan when s/he retires if s/he receives a monthly retirement benefit from MOSERS and was employed by the Missouri Department of Conservation.

3. An employee may enroll him/herself and his/her spouse/child(ren) in an MCHCP dental and/or vision plan when s/he retires if s/he receives a monthly retirement benefit from MPERS.

4. If the retiree's spouse is a state active employee or retiree and enrolled in MCHCP, both spouses may transfer to coverage under the plan in which his/her spouse is enrolled or from his/her spouse's coverage to his/her coverage at any time as long as both spouses are eligible for MCHCP coverage and their coverage is continuous.

5. If a retiree who is eligible for coverage elects not to be continuously covered for him/herself and spouse/child(ren) with MCHCP from the date first eligible, or does not apply for coverage for him/herself and spouse/child(ren) within thirty-one (31) days of his/her eligibility date, the retiree and his/her spouse/child(ren) shall not thereafter be eligible for coverage unless specified elsewhere herein.

6. An individual enrolled in another non-MCHCP **Medicare Advantage (Part C) and/or Medicare Prescription Drug Plan (Part D)** is not eligible for medical coverage.

(G) Dependent Coverage. Eligible dependents include:

1. Spouse.

A. State employees eligible for coverage under the Missouri Department of Transportation, Department of Conservation, or the Highway Patrol medical plans may not enroll as a spouse under MCHCP.

B. Active Employee Coverage of a Spouse.

(I) If both spouses are active state employees covered by MCHCP, each spouse must enroll separately.

C. Retiree Coverage of a Spouse.

(I) A state retiree may enroll as a spouse under an employee's coverage or elect coverage as a retiree.

(II) At retirement, an employee eligible for coverage under the Missouri Department of Transportation, Department of Conservation, or the Highway Patrol medical plans may enroll as a spouse under MCHCP;

2. Children.

A. Children may be covered through the end of the month in which they turn twenty-six (26) years old if they meet one (1) of the following criteria:

(I) Natural child of subscriber or spouse;
 (II) Legally-adopted child of subscriber or spouse;
 (III) Child legally placed for adoption of subscriber or spouse;

(IV) Stepchild of subscriber. Such child will continue to be considered a dependent after the stepchild relationship ends due to the death of the child's natural parent and subscriber's spouse;

(V) Foster child of subscriber or spouse. Such child will continue to be considered a dependent child after the foster child relationship ends by operation of law when the child ages out if the foster child relationship between the subscriber or spouse and the child was in effect the day before the child ages out;

(VI) Grandchild for whom the subscriber or spouse has legal guardianship or legal custody;

(VII) A child for whom the subscriber or spouse is the court-ordered legal guardian under a guardianship of a minor. Such child will continue to be considered a dependent child after the guardianship ends by operation of law when the child becomes eighteen (18) years old if the guardianship of a minor relationship between the subscriber or spouse and the child was in effect the day before the child became eighteen (18) years old;

(VIII) *[Newborn] Child of a dependent [or child of a dependent when paternity by the dependent is established after birth so long as the parent is a dependent on the newborn's date of birth or the date the child's paternity was established and continues to be covered as a dependent of the subscriber;] as long as the parent is a dependent on the child's date of birth. The dependent and his/her child must remain continuously covered on the plan from the dependent's child's date of birth for the child of the dependent to remain eligible;*

(IX) *[Child for whom the subscriber or spouse is required to provide coverage under a Qualified Medical Child Support Order (QMCSO); or] Child of a dependent when paternity by the dependent is established after birth as long as the parent is a dependent on the date the child's paternity was established. The dependent and his/her child must remain continuously covered on the plan from the dependent's child's paternity establishment date for the child of the dependent to remain eligible;*

(X) *[A child under twenty-six (26) years, who is a state employee, may be covered as a dependent of a state employee.] Child for whom the subscriber or spouse is required to provide coverage under a Qualified Medical Child Support Order (QMCSO); or*

(XI) **A child under twenty-six (26) years, who is a state employee, may be covered as a dependent of a state employee.**

B. A child who is twenty-six (26) years old or older and is permanently disabled in accordance with subsection (5)(G), may be covered only if such child was disabled the day before the child turned twenty-six (26) years old and has remained continuously disabled.

C. A child may only be covered by one (1) parent if his/her parents are married to each other and are both covered under an MCHCP medical plan.

D. A child may have dual coverage if the child's parents are divorced or have never married, and both have coverage under an MCHCP medical plan. MCHCP will only pay for a service once, regardless of whether the claim for the child's care is filed under multiple subscribers' coverage. If a child has coverage under two (2) subscribers, the child will have a separate deductible, copayment, and coinsurance under each subscriber. The claims administrator will process the claim and apply applicable cost-sharing using the coverage of the subscriber who files the claim first. The second claim for the same services will not be covered. If a provider files a claim simultaneously under both subscribers' coverage, the claim will be processed under the subscriber whose birthday is first in the calendar year. If both subscribers have the same birthday, the claim will be processed under the subscriber whose coverage has been in effect for

the longest period of time; or

3. Changes in dependent status. If a dependent loses his/her eligibility, the subscriber must notify MCHCP within thirty-one (31) days of the loss of eligibility. Coverage will end on the last day of the month that the completed form is received by MCHCP or the last day of the month MCHCP otherwise receives credible evidence of loss of eligibility under the plan.

(3) Enrollment Procedures.

(A) Active Employee Coverage.

1. Statewide Employee Benefit Enrollment System (SEBES). A new employee must enroll or waive coverage through SEBES at www.sebes.mo.gov or through another designated enrollment system within thirty-one (31) days of his/her hire date or the date the employer notifies the employee that s/he is an eligible variable-hour employee. If enrolling a spouse or child(ren), proof of eligibility must be submitted as defined in section (5).

2. An active employee may elect, change, or cancel coverage for the next plan year during the annual open enrollment period that runs October 1 through October 31 of each year.

3. An active employee may *[apply for] elect or change* coverage for himself/herself and/or for his/her spouse/child(ren) if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. An employee *[and] or* his/her spouse/child(ren) may enroll within sixty (60) days *[if s/he involuntarily loses] due to an involuntary loss of* employer-sponsored coverage under one (1) of the following circumstances:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends; or

C. If an active employee or his/her spouse/child(ren) loses MO HealthNet or Medicaid status, s/he may enroll in an MCHCP plan within sixty (60) days of the date of loss; or

D. If an active employee or active employee's spouse receives a court order stating s/he is responsible for covering a child, the active employee may enroll the child in an MCHCP plan within sixty (60) days of the court order.

4. Default enrollment.

[4./A.] If an active employee is enrolled in the PPO 300 or PPO 600 Plan and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the PPO *[600] 1250* Plan provided through the vendor the employee is enrolled in, effective the first day of the next calendar year.

[A./B.] If an active employee is enrolled in the Health Savings Account (HSA) Plan *[(formerly High Deductible Health Plan)]* and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled in the HSA Plan at the same level of coverage.

[B./C.] If an active employee is enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled in the TRICARE Supplemental Plan at the same level of coverage.

[C./D.] Married state employees who are both MCHCP members who do not complete enrollment during the open enrollment period, will continue to meet one (1) family deductible and out-of-pocket maximum if they chose to do so during the previous plan year.

[5./E.] If an active employee is enrolled in dental and/or

vision coverage and does not complete open enrollment to cancel coverage or change the current level of coverage during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

[6./5. If an active employee submits an Open Enrollment Worksheet or an Enroll/Change/Cancel form that is incomplete or contains obvious errors, MCHCP will notify the employee of such by mail, phone, or secure message. The employee must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(B) Retiree Coverage.

1. To enroll or continue coverage for him/herself and his/her dependents or spouse/child(ren) at retirement, the employee must submit one (1) of the following:

A. A completed enrollment form within thirty-one (31) days of retirement date even if the retiree is continuing coverage as a variable-hour employee after retirement. Coverage is effective on retirement date; or

B. A completed enrollment form thirty-one (31) days before retirement date to have his/her first month's retirement premium deducted and divided between his/her last two (2) payrolls and the option to pre-pay premiums through the cafeteria plan; or

C. A completed enrollment form within thirty-one (31) days of retirement date with proof of prior medical, dental, or vision coverage under a group or individual insurance policy for six (6) months immediately prior to his/her retirement if s/he chooses to enroll in an MCHCP plan at retirement and has had insurance coverage for six (6) months immediately prior to his/her retirement.

2. A retiree may later add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A retiree may enroll his/her spouse/child(ren) within sixty (60) days *[if the spouse/child(ren) involuntarily loses]* **due to an involuntary loss** of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

3. If coverage was not maintained while on disability, the employee may enroll him/herself and his/her spouse/child(ren) within thirty-one (31) days of the date the employee is eligible for retirement benefits subject to the eligibility provisions herein.

4. A retiree may change from one (1) medical plan to another during open enrollment, but cannot add coverage for a spouse/child(ren). If a retiree is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

5. *[If a retiree with Medicare is enrolled in the PPO 300 Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled at the same level of coverage in the PPO 300 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.]* **Default enrollment.**

[A. If a retiree with Medicare is enrolled in the PPO 600 Plan and does not complete enrollment during the open

enrollment period, the retiree and his/her dependents will be enrolled at the same level of coverage in the PPO 600 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.]

A. A retiree with Medicare and dependents with Medicare will be enrolled in the Medicare Advantage Plan.

(I) If the retiree or a dependent becomes Medicare eligible in January of the next calendar year, they will be enrolled in the Medicare Advantage Plan.

(II) If the retiree does not have Medicare Part B, and does not complete enrollment during the open enrollment period, the retiree and his/her dependents without Medicare will be enrolled in the PPO 1250 plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.

B. If a retiree with Medicare is enrolled in the PPO 300 or PPO 600 Plan and does not complete enrollment during the open enrollment period, and has dependents who are not covered by Medicare, his/her dependents without Medicare will be enrolled in the PPO 1250 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.

[B./C. If a retiree without Medicare is enrolled in the PPO 300 Plan or PPO 600 Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents **without Medicare** will be enrolled *[at the same level of coverage]* in the PPO **[600/ 1250]** Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.

[C./D. If a retiree **without Medicare** is enrolled in the HSA Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents **without Medicare** will be enrolled in the HSA Plan **through the vendor the retiree is enrolled in** at the same level of coverage, **effective the first day of the next calendar year.**

[(I) Retirees enrolled in the HSA Plan who become Medicare eligible or their dependents become Medicare eligible during the next plan year will be defaulted to the PPO 600 Plan effective the first day of the next calendar year, if they do not complete enrollment during the open enrollment period.]

[D./E. If a retiree **without Medicare** is currently enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled in the TRICARE Supplemental Plan at the same level of coverage, **effective the first day of the next calendar year.**

[E. If a retiree is enrolled in the Medicare Prescription Drug Only Plan and does not complete enrollment during the open enrollment period, the retiree and his/her Medicare eligible dependents will be enrolled in the Medicare Prescription Drug Only Plan at the same level of coverage.]

6. If a retiree is enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

7. If a retiree submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Retiree Enrollment form that is incomplete or contains obvious errors, MCHCP will notify the retiree of such by mail, phone, or secure message. The retiree must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(C)/F. Terminated Vested Coverage.

1. A terminated vested subscriber may later add a spouse/child(ren) to his/her coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the

life event. It is the employee's responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A terminated vested subscriber may enroll his/her spouse/child(ren) within sixty (60) days *[if the spouse/child(ren) involuntarily loses]* **due to an involuntary loss of** employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

2. An enrolled terminated vested subscriber may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If an enrolled terminated vested subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

3. Default enrollment.

A. A terminated vested subscriber with Medicare and dependents with Medicare will be enrolled in the Medicare Advantage Plan.

(I) If the terminated vested subscriber or a dependent becomes Medicare eligible in January of the next calendar year, they will be enrolled in the Medicare Advantage Plan.

(II) If the terminated vested subscriber does not have Medicare Part B, and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents without Medicare will be enrolled in the PPO 1250 plan provided through the vendor the terminated vested subscriber is enrolled in, effective the first day of the next calendar year.

[3./B. If a terminated vested subscriber without Medicare is enrolled in the PPO 300 or PPO 600 Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents **without Medicare** will be enrolled *[at the same level of coverage]* in the PPO **[600]** **1250** Plan provided through the vendor the terminated vested subscriber is enrolled in, effective the first day of the next calendar year.

[A. *If a terminated vested subscriber with Medicare is enrolled in the PPO 300 Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled at the same level of coverage in the PPO 300 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.*

B. *If a terminated vested subscriber with Medicare is enrolled in the PPO 600 Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled at the same level of coverage in the PPO 600 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.]*

C. If a terminated vested subscriber **without Medicare** is enrolled in the HSA Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents **without Medicare** will be enrolled in the HSA Plan **through the vendor the terminated vested subscriber is enrolled in** effective the first day of the next calendar year, at the same level of coverage.

[(I) Terminated vested subscribers enrolled in the HSA Plan who become Medicare eligible during the next plan year will be defaulted to the PPO 600 Plan effective the first day of the next calendar year, if they do not complete enrollment during the open enrollment period.]

D. If a terminated vested subscriber **without Medicare** is

enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled in the TRICARE Supplemental Plan effective the first day of the next calendar year, at the same level of coverage.

[4./E. If a terminated vested subscriber is enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

[5./4. If a terminated vested subscriber submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Terminated Vested Enrollment form that is incomplete or contains obvious errors, MCHCP will notify the terminated vested subscriber of such by mail, phone, or secure message. The terminated vested subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(D) Long-Term Disability Coverage.

1. A long-term disability subscriber may add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A long-term disability subscriber may enroll his/her spouse/child(ren) within sixty (60) days *[if the spouse/child(ren) involuntarily loses]* **due to an involuntary loss of** employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

2. An enrolled long-term disability subscriber may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If an enrolled long-term disability subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

3. Default enrollment.

A. A long-term disability subscriber with Medicare and dependents with Medicare will be enrolled in the Medicare Advantage Plan.

(I) If the long-term disability subscriber or a dependent becomes Medicare eligible in January of the next calendar year, they will be enrolled in the Medicare Advantage Plan.

(II) If the long-term disability subscriber does not have Medicare Part B, and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents without Medicare will be enrolled in the PPO 1250 plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.

[3./B. If a long-term disability subscriber without Medicare is enrolled in the PPO 300 or PPO 600 Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents **without Medicare** will be enrolled *[at the same level of coverage]* in the PPO **[600]** **1250** Plan provided through the vendor the long-term disability subscriber is enrolled in, effective the first day of the next calendar year.

[A./C. If a long-term disability subscriber with Medicare is enrolled in the PPO 300 or PPO 600 Plan and does not complete

enrollment during the open enrollment period **and has dependents who are not covered by Medicare**, the long-term disability subscriber and his/her dependents **without Medicare** will be enrolled *[at the same level of coverage]* in the PPO **[300] 1250** Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.

[B. If a long-term disability subscriber with Medicare is enrolled in the PPO 600 Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled at the same level of coverage in the PPO 600 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.]

[C./D. If a long-term disability subscriber without Medicare is enrolled in the HSA Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents without Medicare will be enrolled in the HSA Plan through the vendor the long-term disability subscriber is enrolled in at the same level of coverage, effective the first day of the next calendar year.]

[(I) Long-term disability subscribers enrolled in the HSA Plan who become Medicare eligible during the next plan year will be defaulted to the PPO 600 Plan effective the first day of the next calendar year, if they do not complete enrollment during the open enrollment period.]

[D./E. If a long-term disability subscriber without Medicare is enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents without Medicare will be enrolled in the TRICARE Supplemental Plan effective the first day of the next calendar year, at the same level of coverage.]

[4./F. If a long-term disability subscriber is enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.]

[5./4. If a long-term disability subscriber submits an Open Enrollment Worksheet or an Enroll/Change/Cancel form that is incomplete or contains obvious errors, MCHCP will notify the long-term disability subscriber of such by mail, phone, or secure message. The long-term disability subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.]

(E) Survivor Coverage.

1. A survivor must submit a survivor enrollment form and a copy of the death certificate within thirty-one (31) days of the first day of the month after the death of the employee.

A. If the survivor does not elect coverage within thirty-one (31) days of the first day of the month after the death of the employee, s/he cannot enroll at a later date.

B. If the survivor marries, has a child, adopts a child, or a child is placed with the survivor, the spouse/child(ren) must be added within thirty-one (31) days of birth, adoption, placement, or marriage.

C. If eligible spouse/child(ren) are not enrolled when first eligible, they cannot be enrolled at a later date.

2. A survivor may later add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A survivor may enroll his/her spouse/child(ren) within sixty (60) days *[if the*

spouse/child(ren) involuntarily loses] due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

3. A survivor may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If a survivor is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

4. Default enrollment.

A. A survivor with Medicare and dependents with Medicare will be enrolled in the Medicare Advantage Plan.

(I) If the survivor or a dependent becomes Medicare eligible in January of the next calendar year, they will be enrolled in the Medicare Advantage Plan.

(II) If the survivor does not have Medicare Part B, and does not complete enrollment during the open enrollment period, the survivor and his/her dependents without Medicare will be enrolled in the PPO 1250 plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.

[4./B. If a survivor without Medicare is enrolled in the PPO 300 or PPO 600 Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents without Medicare will be enrolled [at the same level of coverage] in the PPO [600] 1250 Plan provided through the vendor the survivor is enrolled in, effective the first day of the next calendar year.]

[A./C. If a survivor with Medicare is enrolled in the PPO 300 or PPO 600 Plan and does not complete enrollment during the open enrollment period and has dependents who are not covered by Medicare, the survivor and his/her dependents without Medicare will be enrolled [at the same level of coverage] in the PPO [300] 1250 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.]

[B. If a survivor with Medicare is enrolled in the PPO 600 Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents will be enrolled at the same level of coverage in the PPO 600 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.]

[C./D. If a survivor without Medicare is enrolled in the HSA Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents without Medicare will be enrolled in the HSA Plan through the vendor the survivor is enrolled in at the same level of coverage, effective the first day of the next calendar year.]

[(I) Survivors who are enrolled in the HSA Plan who become Medicare eligible during the next plan year will be defaulted to the PPO 600 Plan effective the first day of the next calendar year, if they do not complete enrollment during the open enrollment period.]

[D./E. If a survivor without Medicare is enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents without Medicare will be enrolled in the TRICARE Supplemental Plan effective the first day of the next calendar year, at the same level of coverage.]

[5./F. If a survivor is enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the survivor and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.]

[6./5. If a survivor submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Survivor Enrollment form that is

incomplete or contains obvious errors, MCHCP will notify the survivor of such by mail, phone, or secure message. The survivor must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(5) Proof of Eligibility. Proof of eligibility documentation is required for all dependents and subscribers, as necessary. Enrollment is not complete until proof of eligibility is received by MCHCP. A subscriber must include his/her MCHCPid or Social Security number on the documentation. If proof of eligibility is not received, MCHCP will send a letter requesting it from the subscriber. Except for open enrollment, documentation must be received within thirty-one (31) days of the date MCHCP processed the enrollment, or coverage will not take effect for those individuals whose proof of eligibility was not received. MCHCP reserves the right to request that such proof of eligibility be provided at any time upon request. If such proof is not received or is unacceptable as determined by MCHCP, coverage will terminate or never take effect. If enrolling during open enrollment, proof of eligibility must be received by November 20, or coverage will not take effect the following January 1 for those individuals whose proof of eligibility was not received. If invalid proof of eligibility is received, the subscriber is allowed an additional ten (10) days from the initial due date to submit valid proof of eligibility.

(A) When enrolling a newborn **child**, the *[member]* **subscriber** must notify MCHCP of the birth verbally or in writing within thirty-one (31) days of the birth date. MCHCP will then send an enrollment form and letter notifying the *[member]* **subscriber** of the steps to initiate coverage. The *[member]* **subscriber** is allowed an additional ten (10) days from the date of the plan notice to return the enrollment form. Coverage will not begin unless the enrollment form is received within thirty-one (31) days of the birth date or ten (10) days from the date of the notice, whichever is later. Newborn proof of eligibility must be submitted within ninety (90) days of the birth date. If proof of eligibility is not received, coverage will terminate on day ninety-one (91) from the birth date.

(G) Disabled Dependent.

1. A new employee may enroll his/her permanently disabled child or an enrolled permanently disabled dependent turning age twenty-six (26) years and may continue coverage beyond age twenty-six (26) years, provided the following documentation is submitted to the plan prior to the **end of the month of the dependent's twenty-sixth birthday** for the enrolled permanently disabled dependent or within thirty-one (31) days of enrollment of a new employee and his/her permanently disabled child:

A. Evidence from the Social Security Administration (SSA) that the permanently disabled dependent or child was entitled to and receiving disability benefits prior to turning age twenty-six (26) years; and

B. A benefit verification letter dated within the last twelve (12) months from the SSA confirming the child is still considered disabled.

2. If a disabled dependent or child over the age of twenty-six (26) years is determined to be no longer disabled by the SSA, coverage will terminate the last day of the month in which the disability ends or will never take effect for new enrollment requests.

3. Once the disabled dependent's coverage is cancelled or terminated, s/he will not be able to enroll at a later date.

(8) Voluntary Cancellation of Coverage.

(D) A subscriber may only cancel dental and/or vision coverage during the year for him/herself or his/her dependents for one (1) of the following reasons:

1. Upon retirement;
2. When beginning a leave of absence;
3. No longer eligible for coverage; *[or]*
4. When new coverage is taken through other employment~~./.~~; **or**
5. **When the member enrolls in Medicaid.**

(9) Continuation of Coverage.

(A) Leave of Absence.

1. An employee on an approved leave of absence may continue participation in the plan by paying the required contributions. The employing department must officially notify MCHCP of the leave of absence and any extension of the leave of absence by submitting the required form through eMCHCP. The employee will receive a letter, Leave of Absence Enrollment form, and bill (if applicable) from MCHCP to continue coverage. If the completed form and payment (if applicable) are returned within *ten (10)/ fourteen (14)* days of the date of the letter, coverage will continue. The employee will be set up on direct bill unless the employee and affected dependents are transferred to the plan in which his/her spouse is enrolled.

2. If the employee does not elect to continue coverage, coverage for the employee and his/her dependents is terminated effective the last day of the month in which the employee is employed.

3. If the employee's spouse is an active employee or retiree, the employee and any dependents may transfer to the plan in which the spouse is enrolled if the transfer is elected on the Leave of Absence Enrollment form. Transfer is effective the first of the month following the date of leave. If the employee wishes to be covered individually at a later date, s/he can make the change as long as coverage is continuous. When the employee returns to work, s/he and his/her spouse must be covered individually.

4. Any employee on an approved leave of absence who was a member of MCHCP when the approved leave began, but who subsequently terminated coverage with MCHCP while on leave, may re-enroll in his/her coverage in the plan at the same level (employee only or employee and dependents) upon returning to employment directly from the leave or if the employee was on leave of absence during open enrollment or while on leave of absence leave had a qualifying life event or loss of employer-sponsored coverage, the employee may change plans and add spouse/child(ren). When a leave of absence employee returns to work and MCHCP receives a state contribution for the month s/he returned, s/he will be charged the applicable active employee premium for that month. For coverage to be reinstated, the employee must submit a completed Enroll/Change/Cancel form within thirty-one (31) days of returning to work. Coverage is reinstated on the first of the month coinciding with or after the date the form is received. Coverage will be continuous if the employee returns to work in the subsequent month following the initial leave date.

5. If the employee chooses to maintain employee coverage but not coverage for his/her dependents, the employee is eligible to regain dependent coverage upon return to work.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed amendment covering this same material is published in this issue of the Missouri Register.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN

Division 10—Health Care Plan Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.030 Contributions. The Missouri Consolidated Health Care Plan is amending sections (6) and (7).

PURPOSE: This amendment revises the Missouri Consolidated Health Care Plan contribution methodology for retiree coverage;

removes language related to the Medicare Prescription Drug Only Plan; and renumbers as necessary.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the *Missouri Register*. This emergency amendment complies with the protections extended by the *Missouri and United States Constitutions* and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.

(6) The Missouri Consolidated Health Care Plan (MCHCP) contribution toward retiree coverage is based on either of the following:

(A) *[It]* **The contribution percentage** is calculated by using the number of full creditable years of service at retirement as reported to MCHCP by Missouri State Employees' Retirement System (MOSERS) or Public School Retirement System (PSRS) multiplied by two and one half percent (2.5%). The resulting product shall be capped at sixty-five percent (65%), or in other words the retiree's years of service is capped at twenty-six (26) years. *[For Medicare retirees, the computed percentage is multiplied by the retiree only PPO 600 Plan total premium. For non-Medicare retirees, the computed percentage is multiplied by the retiree only PPO 600 Plan total premium with the tobacco-free incentive and the partnership incentive. The resulting product is the MCHCP contribution, which shall be subtracted from the total premium of the plan chosen by the retiree. The difference is the amount of the retiree contribution toward the total premium. In addition, for Medicare retirees covering dependents, MCHCP will contribute for the dependent portion of the premium the lesser of the following: two and one half percent (2.5%) multiplied by the number of full creditable years of service at retirement (capped at twenty-six (26) years) multiplied by the difference in premium of the retiree only PPO 600 Plan and the premium of the PPO 600 Plan at the rate tier the retiree has selected or the dollar amount MCHCP contributes for the dependent portion of the PPO 600 premium for an active employee at the rate tier the retiree has selected. For non-Medicare retirees, MCHCP will contribute for the dependent portion of the premium the lesser of the following: two and one half percent (2.5%) multiplied by the number of full creditable years of service at retirement (capped at twenty-six (26) years) multiplied by the difference in premium of the retiree only PPO 600 Plan total premium with tobacco-free incentive and partnership*

incentive and the premium of the PPO 600 Plan at the rate tier the retiree has selected or the dollar amount the MCHCP contributes for the dependent portion of the PPO 600 premium for an active employee at the rate tier the retiree has selected. The above calculations can be written by formula as follows:]

[1. Medicare Retiree MCHCP contribution = (2.5% x full creditable years of service (up to 26 years) x Retiree only PPO 600 Plan total premium) + Medicare Retiree MCHCP dependent contribution (if any);

2. Non-Medicare Retiree MCHCP contribution = 2.5% x full creditable years of service (up to 26 years) x Retiree only PPO 600 Plan total premium with tobacco-free incentive and the partnership incentive + Non-Medicare Retiree MCHCP dependent contribution (if any);

3. Medicare Retiree MCHCP dependent contribution = lesser of (2.5% x full creditable years of service (up to 26 years) x (PPO 600 Plan total premium at the rate tier the retiree has selected – Retiree only PPO 600 Plan total premium)) or the dollar amount MCHCP contributes for the dependent portion of the PPO 600 premium for an active employee at the rate tier the retiree has selected; or

4. Non-Medicare Retiree MCHCP dependent contribution = lesser of (2.5% x full creditable years of service (up to 26 years) x (PPO 600 Plan total premium with tobacco-free incentive and partnership incentive at the rate tier the retiree has selected – Retiree only PPO 600 Plan total premium with tobacco-free incentive and partnership incentive)) or the dollar amount MCHCP contributes for the dependent portion of the PPO 600 premium for an active employee at the rate tier the retiree has selected;]

1. Medicare retirees.

A. For Medicare retirees, the contribution percentage is multiplied by the retiree only Medicare Advantage Plan total premium. The resulting product is the MCHCP contribution, which shall be subtracted from the Medicare Advantage total premium. The difference is the amount of the retiree contribution toward the total premium.

B. For Medicare retirees covering Medicare-eligible dependents, MCHCP will contribute for the dependent portion of the premium the lesser of the following: the contribution percentage multiplied by the Medicare Advantage premium, or the dollar amount MCHCP contributes for the dependent portion of the PPO 1250 premium for an active employee at the rate tier the retiree has selected.

C. For Medicare retirees covering non-Medicare eligible dependents, MCHCP will contribute for the dependent portion of the premium the lesser of the following: the contribution percentage multiplied by the difference in premium of the retiree only Medicare Advantage Plan and the premium of the dependent portion of the PPO 1250 Plan at the rate tier the retiree has selected, or the dollar amount MCHCP contributes for the dependent portion of the PPO 1250 premium for an active employee at the rate tier the retiree has selected.

2. Non-Medicare retirees.

A. For non-Medicare retirees, the contribution percentage is multiplied by the retiree only PPO 1250 Plan total premium with the tobacco-free incentive and the partnership incentive. The resulting product is the MCHCP contribution, which shall be subtracted from the total premium of the plan chosen by the retiree. The difference is the amount of the retiree contribution toward the total premium.

B. For non-Medicare retirees covering Medicare-eligible dependents, MCHCP will contribute for the dependent portion of the premium the lesser of the following: the contribution percentage multiplied by the Medicare Advantage premium, or the dollar amount MCHCP contributes for the dependent portion of the PPO 1250 premium for an active employee at the rate tier the retiree has selected.

C. For non-Medicare retirees covering non-Medicare eligible dependents, MCHCP will contribute for the dependent portion of the premium the lesser of the following: contribution percentage multiplied by the difference in premium of the retiree only PPO 1250 Plan total premium with tobacco-free incentive and partnership incentive and the premium of the PPO 1250 Plan at the rate tier the retiree has selected, or the dollar amount MCHCP contributes for the dependent portion of the PPO 1250 premium for an active employee at the rate tier the retiree has selected.

(B) For those retiring prior to July 1, 2002, the amount calculated in subsection [(3)](6)(A) is compared to the flat dollar amount that was contributed for the same rate tier in 2002. The retiree's subsidy is the greater of the amount calculated in subsection [(3)](6)(A) or the flat dollar amount that was contributed in 2002.

[(7) The Missouri Consolidated Health Care Plan (MCHCP) contribution toward the retiree and survivor premium for members enrolled in the Medicare Prescription Drug Only Plan is based on either of the following:

(A) The subsidy is calculated by using the number of full creditable years of service at retirement as reported to MCHCP by MOSERS or PSRS multiplied by two and one half percent (2.5%), and capped at sixty-five percent (65%). The computed percentage is multiplied by the Medicare Prescription Drug Only Plan premium at the rate tier the retiree selected. The resulting product is the MCHCP contribution, which shall be subtracted from the total Medicare Prescription Drug Only Plan premium. The difference is the amount of the retiree contribution toward the Medicare Prescription Drug Only Plan premium. The above calculation can be written by formula as follows: Retiree MCHCP contribution = 2.5% x full creditable years of service (up to 26 years) x Medicare Prescription Drug Only Plan premium; or

(B) For those retiring prior to July 1, 2002, the amount calculated in subsection (7)(A) is compared to fifty-nine percent (59%) of the total premium for the Medicare Prescription Drug Only Plan. The retiree's subsidy is the greater of the amount calculated in subsection (7)(A) or fifty-nine percent (59%) of the Medicare Prescription Drug Only Plan.]

[(8)](7) Premium. Payroll deductions, Automated Clearing House (ACH) transactions, debit cards, credit cards, and/or direct bills are processed by MCHCP.

(A) Active Employee Whose Payroll Information is Housed in the SAM II Human Resource System.

1. Monthly medical premium payroll deductions are divided in half and taken by MCHCP at the end of the prior month and the fifteenth of the current month for the current month's coverage (example: September 30 and October 15 payroll deductions are taken for October medical premiums).

2. Monthly dental and vision premium payroll deductions are divided in half and taken by MCHCP on the fifteenth of the current month and the end of the current month for the current month's dental and vision coverage (example: October 15 and October 31 payroll deductions are taken for October dental and vision premiums).

3. If a subscriber owes premiums outside the current month, payroll deductions for all other premiums owed will be divided equally and taken from the subscriber's future payrolls as follows:

A. Fifty dollars (\$50) or less, deduction will be taken from one (1) payroll;

B. Fifty-one dollars (\$51) to one hundred dollars (\$100) will be deducted from two (2) payrolls;

C. One hundred one dollars (\$101) to two hundred dollars (\$200) will be deducted from three (3) payrolls;

D. Two hundred one dollars (\$201) to three hundred dollars (\$300) will be deducted from four (4) payrolls;

E. Three hundred one dollars (\$301) to four hundred dollars

(\$400) will be deducted from five (5) payrolls;

F. Four hundred one dollars (\$401) to five hundred dollars (\$500) will be deducted from six (6) payrolls;

G. Five hundred one dollars (\$501) to six hundred dollars (\$600) will be deducted from seven (7) payrolls;

H. Six hundred one dollars (\$601) to seven hundred dollars (\$700) will be deducted from eight (8) payrolls;

I. Seven hundred one dollars (\$701) to eight hundred dollars (\$800) will be deducted from nine (9) payrolls;

J. Eight hundred one dollars (\$801) to nine hundred dollars (\$900) will be deducted from ten (10) payrolls;

K. Nine hundred one dollars (\$901) to one thousand dollars (\$1,000) will be deducted from eleven (11) payrolls; and

L. One thousand one dollars (\$1,001) and over will be deducted from twelve (12) payrolls.

4. If the active employee's check is not sufficient to cover his/her premium, the active employee will receive a monthly bill for the premium.

(B) Active Employee Whose Payroll Information is not Housed in the SAM II Human Resource System.

1. Premium payroll deductions are submitted to MCHCP monthly from the agency based on the deductions taken from the employee's payroll.

A. Medical premium payroll deduction received at the end of the month is applied to the employee's next month's coverage (example: September 30 payroll deduction is taken for the October medical premium).

B. Dental and vision premium payroll deductions received at the end of the month are applied to the current month's dental and vision coverage (example: September 30 payroll deductions are taken for September dental and vision premiums).

C. If a subscriber owes past-due premiums, payroll deductions for current premiums along with the payroll deductions for past-due premiums may be taken at the discretion of the employer.

2. If the active employee's check is not sufficient to cover his/her premium, the active employee will receive a monthly bill for the premium.

(C) Retirees and Survivors Premiums From Benefit Check.

1. Deduction amounts are received monthly from MOSERS based on the deductions taken from the benefit checks. Medical, dental, and vision deductions received at the end of the month pay for the next month's coverage (example: September 30 benefit check deduction is taken for October medical, dental, and vision premiums).

2. If a retiree or survivor is currently having deductions taken from his/her benefit check and owes past-due premiums due to a change in his/her deductions, MCHCP will contact MOSERS to determine if the benefit check is large enough to cover the past-due premiums. If the benefit check is large enough to cover the past-due premiums, deductions will be divided and taken from the retiree or survivor's next three (3) benefit checks and coverage will be continuous. If the retiree or survivor's benefit check is not large enough to cover the deductions, and the retiree or survivor has failed to make the necessary premium payments, coverage will be terminated due to nonpayment, effective the last day of the month a full premium was received.

(D) Direct Bill of Premium Owed By Subscribers Whose Premium is not Deducted from Payroll or Benefit Check.

1. Premiums are billed on the last working day of the month for the next month's coverage. Premiums are due fifteen (15) days from the last day of the month in which they are billed (example: bill mailed September 30 for October medical, dental, and vision premiums, premium due October 15).

2. A subscriber may elect to pay premiums by ACH electronic payment. In that case, the subscriber agrees that he/she will not receive a monthly bill.

A. Premiums are deducted from a subscriber's bank account on the fifth of the month to pay for the current month's coverage (example: October 5 deduction taken for October medical, dental,

and vision premiums).

B. If there are insufficient funds, MCHCP will bill the subscriber for the premium owed. The due date of the premium owed shall not change due to insufficient funds.

[(9)](8) Premium Payments.

(A) By enrolling in coverage under MCHCP, an active employee agrees that MCHCP may deduct the member's contribution toward the total premium from the subscriber's paycheck. Payment for the first month's premium is made by payroll deduction. Subsequent premium payments are deducted from the active employee's paycheck. If the active employee's check is not sufficient to cover his/her premium, the active employee agrees to pay MCHCP by check, money order, ACH or cash, or by any other monetary transaction supported by MCHCP.

(B) By enrolling in coverage under MCHCP, the retiree or survivor agrees that MCHCP will automatically deduct the premium from the retiree or survivor's benefit check. The retiree or survivor may choose to receive a monthly bill in lieu of an automatic deduction. If the retiree or survivor's deduction is not sufficient to cover his/her premium or the retiree or subscriber chooses to receive a monthly bill, the retiree or survivor agrees to pay MCHCP by check, money order, ACH or cash, or by any other monetary transaction supported by MCHCP.

(C) If the subscriber fails to make the necessary premium payments, coverage terminates on the last day of the month for which full premium payment was received. The subscriber is responsible for claims submitted after the termination date.

1. If a non-Medicare subscriber fails to pay premiums by the required due date, MCHCP allows a thirty-one- (31-) day grace period from the due date. In the event that MCHCP has not received payment of premium at the end of the thirty-one- (31-) day grace period, coverage will be retroactively terminated on the last day of the month for which full premium payment was received. The subscriber will be responsible for the value of the services rendered after the retroactive termination date, including, but not limited to, the grace period.

2. If a Medicare primary subscriber fails to pay premiums by the required due date, MCHCP allows a sixty- (60-) day grace period from the due date. In the event that MCHCP has not received payment of premium at the end of the sixty- (60-) day grace period, coverage will be terminated effective the end of month in which the sixty- (60-) day grace period ends.

[(10)](9) Refunds of overpayments are limited to the amount overpaid during the twelve- (12-) month period ending at the end of the month preceding the month during which notice of overpayment is received by MCHCP.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed amendment covering this same material is published in this issue of the Missouri Register.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN**

**Division 10—Health Care Plan
Chapter 2—State Membership**

EMERGENCY AMENDMENT

22 CSR 10-2.045 Plan Utilization Review Policy. The Missouri Consolidated Health Care Plan amending section (1).

PURPOSE: This amendment adds preauthorization requirements for chemotherapy for cancer diagnosis, dialysis, and specialty injectibles; revises preauthorization requirements for surgery (outpatient); alphabetizes the list of medical services, and renumbers as necessary.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program has the following components:

(A) Preauthorization—The claims administrator must authorize some services in advance. Without preauthorization, any claim that requires preauthorization will be denied for payment. Members who have another primary carrier, *[including,] or who are enrolled in the Medicare[,] Advantage Plan* are not subject to this provision except for those services that are not covered by the other primary carrier, but are otherwise subject to preauthorization under this rule. Preauthorization does not verify eligibility or payment. Preauthorizations found to have a material misrepresentation or intentional or negligent omission about the person's health condition or the cause of the condition may be rescinded.

1. The following medical services are subject to preauthorization:

- A. Ambulance services for non-emergent use, whether air or ground;
- B. Anesthesia and hospital charges for dental care for children younger than five (5) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization;
- C. Applied behavior analysis for autism at initial service;
- D. Auditory brainstem implant (ABI);
- E. Bariatric surgery;
- F. Cardiac rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;
- G. Chelation therapy;
- H. Chemotherapy for cancer diagnosis;
- /G./I.* Chiropractic services after twenty-six (26) visits annually;
- /H./J.* Cochlear implant device;
- /I.* Chelation therapy;

/J./K. Dental care;

L. Dialysis

/K./M. Durable medical equipment (DME) over one thousand five hundred dollars (\$1,500) or DME rentals over five hundred dollars (\$500) per month;

/L./N. Genetic testing or counseling;

/M./O. Hearing Aids;

/N./P. Home health care;

/O./Q. Hospice care and palliative services;

/P./R. Hospital inpatient services;

/Q./S. Imaging (diagnostic non-emergent outpatient), including magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positron emission tomography (PET), computerized tomography scan (CT), computerized tomography angiography (CTA), electron-beam computed tomography (EBCT), and nuclear cardiology;

/R./T. Maternity coverage for maternity hospital stays longer than forty-eight (48) hours for vaginal delivery or ninety-six (96) hours for cesarean delivery;

/S./U. Nutritional counseling after six (6) sessions annually;

/T./V. Orthognathic surgery;

/U./W. Orthotics over one thousand dollars (\$1,000);

/V./X. Physical, speech, and occupational therapy and rehabilitation services (outpatient) after sixty (60) combined visits per calendar year;

/W./Y. Procedures with procedure codes ending in "T" (temporary procedure codes used for data collection, experimental, investigational, or unproven procedures);

/X./Z. Prostheses over one thousand dollars (\$1,000);

/Y./AA. Pulmonary rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;

/Z./BB. Skilled nursing facility;

CC. Specialty injectables;

/AA./DD. Surgery (outpatient)—The following outpatient surgical procedures: cornea transplant, potential cosmetic surgery, sleep apnea surgery, implantable stimulators, stimulators for bone growth, spinal surgery (including, but not limited to, artificial disc replacement, fusions, nonpulsed radiofrequency denervation, vertebroplasty, kyphoplasty, spinal cord stimulator trials, spinal cord stimulator implantation, and any unlisted spinal procedure), **total hip arthroplasty, total knee arthroplasty**, and oral surgery (excisions of tumors and cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological exams); and

/BB./EE. Transplants, including requests related to covered travel and lodging.

2. The following pharmacy services included in the prescription drug plan for non-Medicare primary members are subject to preauthorization:

A. Second-step therapy medications that skip the first-step medication trial;

B. Specialty medications;

C. Medications that may be prescribed for several conditions, including some for which treatment is not medically necessary;

D. Medication refill requests that are before the time allowed for refill;

E. Medications that exceed drug quantity and day supply limitations; and

F. Medications with costs exceeding nine thousand nine hundred ninety-nine dollars and ninety-nine cents (\$9,999.99) at retail or the mail order pharmacy and one hundred forty-nine dollars and ninety-nine cents (\$149.99) for compound medications at retail or the mail order pharmacy.

3. Preauthorization timeframes.

A. A benefit determination for non-urgent preauthorization requests will be made within fifteen (15) calendar days of the receipt of the request. The fifteen (15) days may be extended by the claims administrator for up to fifteen (15) calendar days if an extension is needed as a result of matters beyond the claims administrator's control. The claims administrator will notify the member of any neces-

sary extension prior to the expiration of the initial fifteen- (15-) calendar-day period. If a member fails to submit necessary information to make a benefit determination, the member will be given at least ninety (90) calendar days from receipt of the extension notice to respond with additional information.

B. A benefit determination for urgent preauthorization requests will be made as soon as possible based on the clinical situation, but in no case later than twenty-four (24) hours of the receipt of the request;

AUTHORITY: section 103.059, RSMo [2000] 2016. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed amendment covering this same material is published in this issue of the Missouri Register.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 2—State Membership

EMERGENCY RULE

22 CSR 10-2.046 PPO 750 Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 750 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency rule is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule to maintain the integrity of the current health care plan. This emergency rule fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the Missouri Register. This emergency rule complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.

(1) Deductible—per calendar year for network: per individual, seven hundred fifty dollars (\$750); family, one thousand five hundred dollars (\$1,500) and for non-network: per individual, one thousand five hundred dollars (\$1,500); family, three thousand dollars (\$3,000).

(A) Network and non-network deductibles are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Claims will not be paid until the applicable deductible is met.

(C) Services that do not apply to the deductible and for which applicable costs will continue to be charged include, but are not limited to: copayments, charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(D) The family deductible is an embedded deductible with two (2) parts: an individual deductible and an overall family deductible. Each family member must meet his/her own individual deductible amount until the overall family deductible amount is reached. Once a family member meets his/her own individual deductible, the plan will start to pay claims for that individual and any additional out-of-pocket expenses incurred by that individual will not be used to meet the family deductible amount. Once the overall family deductible is met, the plan will start to pay claims for the entire family even if some family members have not met his/her own individual deductible.

(2) Coinsurance—Coinsurance amounts apply to covered services after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(A) Network claims are paid at eighty percent (80%) until the out-of-pocket maximum is met.

(B) Non-network claims are paid at sixty percent (60%) until the out-of-pocket maximum is met.

(3) Out-of-pocket maximum—per calendar year for network: per individual, two thousand two hundred fifty dollars (\$2,250); family, four thousand five hundred dollars (\$4,500) and for non-network: per individual, four thousand five hundred dollars (\$4,500); family, nine thousand dollars (\$9,000).

(A) Network and non-network out-of-pocket maximums are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include, but are not limited to: charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(C) The family out-of-pocket maximum is an embedded out-of-pocket maximum with two (2) parts: an individual out-of-pocket maximum and an overall family out-of-pocket maximum. Each family member must meet his/her own individual out-of-pocket maximum amount until the overall family out-of-pocket maximum amount is reached. Once a family member meets his/her own individual out-of-pocket maximum, the plan will start to pay claims at one hundred percent (100%) for that individual. Once the overall family out-of-pocket maximum is met, the plan will start to pay claims at one hundred percent (100%) for the entire family even if some family members had not met his/her own individual out-of-pocket maximum.

(4) The following services will be paid as a network benefit when provided by a non-network provider:

(A) Emergency services and urgent care;

(B) Covered services that are not available through a network provider within one hundred (100) miles of the member's home. The member must contact the claims administrator before the date of service in order to have a closer non-network provider's claims approved as a network benefit. Such approval is for three (3) months. After three (3) months, the member must contact the claims administrator to reassess network availability;

(C) Covered services when such services are provided in a network hospital or ambulatory surgical center and are an adjunct to a service being performed by a network provider. Examples of such adjunct services include, but are not limited to, anesthesiology, assistant surgeon, pathology, or radiology.

(5) The following services are not subject to deductible, coinsurance, or copayment requirements and will be paid at one hundred percent (100%) when provided by a network provider:

(A) Preventive care;

(B) Nutrition counseling;

(C) A newborn's initial hospitalization until discharge or transfer to another facility if the mother is a Missouri Consolidated Health Care Plan (MCHCP) member at the time of birth; and

(D) Four (4) Diabetes Self-Management Education/Training visits with a certified diabetes educator when ordered by a provider.

(6) Influenza vaccinations provided by a non-network provider will be reimbursed up to twenty-five dollars (\$25) once the member submits a receipt and a reimbursement form to the claims administrator.

(7) Married, active employees who are MCHCP subscribers and have enrolled children may meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must provide the other spouse's Social Security number (SSN) and report the other spouse as eligible for coverage when newly hired and during the open enrollment process. In the medical plan vendor and pharmacy benefit manager system, the spouse with children enrolled will be considered the subscriber and the spouse that does not have children enrolled will be considered a dependent. If both spouses have children enrolled the spouse with the higher Social Security number (SSN) will be considered the subscriber. Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

(8) Each subscriber will have access to payment information of the family unit only when authorization is granted by the adult covered dependent(s).

(9) Expenses toward the deductible and out-of-pocket maximum will be transferred if the member changes non-Medicare medical plans during the plan year or continues enrollment under another subscriber's non-Medicare medical plan within the same plan year.

(10) Copayments.

(A) Emergency room—two hundred fifty dollars (\$250) network and non-network. Deductible and coinsurance requirements apply to emergency room services in addition to the copayment. If a member is admitted to the hospital or the claims administrator considers the claim to be for a true emergency, the copayment is waived.

(B) Inpatient hospitalization—two hundred dollars (\$200) per admission for network and non-network. Deductible and coinsurance requirements apply to inpatient hospitalization services in addition to the copayment.

(11) Maximum plan payment—non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed at one hundred ten percent (110%) of Medicare reimbursement. Members may be held liable for the amount of the fee above the allowed amount.

(12) Any claim must be initially submitted within twelve (12) months following the date of service. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

(13) For a member who is an inpatient on the last calendar day of a plan year and remains an inpatient into the next plan year, the prior

plan year's applicable copayment, deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

(14) Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-2.055. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as a non-network benefit. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

(15) Medicare.

(A) When MCHCP becomes aware that the member is eligible for Medicare benefits, claims will be processed reflecting Medicare coverage.

(B) If a member does not enroll in Medicare when s/he is eligible and Medicare should be the member's primary plan, the member will be responsible for paying the portion Medicare would have paid. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

(C) If a Medicare primary member chooses a provider who has opted out of Medicare, the member will be responsible for paying the portion Medicare would have paid if the service was performed by a Medicare provider. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed rule covering this same material is published in this issue of the Missouri Register.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN

Division 10—Health Care Plan Chapter 2—State Membership

EMERGENCY RULE

22 CSR 10-2.047 PPO 1250 Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 1250 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency rule is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of cov-

erage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule to maintain the integrity of the current health care plan. This emergency rule fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the Missouri Register. This emergency rule complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.

(1) Deductible—per calendar year for network: per individual, one thousand two hundred fifty dollars (\$1,250); family, two thousand five hundred dollars (\$2,500) and for non-network: per individual, two thousand five hundred dollars (\$2,500); family, five thousand dollars (\$5,000).

(A) Network and non-network deductibles are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Claims will not be paid until the applicable deductible is met.

(C) Services that do not apply to the deductible and for which applicable costs will continue to be charged include, but are not limited to: copayments, charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(D) The family deductible is an embedded deductible with two (2) parts: an individual deductible and an overall family deductible. Each family member must meet his/her own individual deductible amount until the overall family deductible amount is reached. Once a family member meets his/her own individual deductible, the plan will start to pay claims for that individual and any additional out-of-pocket expenses incurred by that individual will not be used to meet the family deductible amount. Once the overall family deductible is met, the plan will start to pay claims for the entire family even if some family members have not met his/her own individual deductible.

(2) Coinsurance—coinsurance amounts apply to covered services after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(A) Network claims are paid at eighty percent (80%) until the out-of-pocket maximum is met.

(B) Non-network claims are paid at sixty percent (60%) until the out-of-pocket maximum is met.

(3) Out-of-pocket maximum—per calendar year for network: per individual, three thousand seven hundred fifty dollars (\$3,750); family, seven thousand five hundred dollars (\$7,500) and for non-network: per individual, seven thousand five hundred dollars (\$7,500); family, fifteen thousand dollars (\$15,000).

(A) Network and non-network out-of-pocket maximums are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include, but are not limited to: charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(C) The family out-of-pocket maximum is an embedded out-of-pocket maximum with two (2) parts: an individual out-of-pocket

maximum and an overall family out-of-pocket maximum. Each family member must meet his/her own individual out-of-pocket maximum amount until the overall family out-of-pocket maximum amount is reached. Once a family member meets his/her own individual out-of-pocket maximum, the plan will start to pay claims at one hundred percent (100%) for that individual. Once the overall family out-of-pocket maximum is met, the plan will start to pay claims at one hundred percent (100%) for the entire family even if some family members had not met his/her own individual out-of-pocket maximum.

(4) The following services will be paid as a network benefit when provided by a non-network provider:

(A) Emergency services and urgent care;

(B) Covered services that are not available through a network provider within one hundred (100) miles of the member's home. The member must contact the claims administrator before the date of service in order to have a closer non-network provider's claims approved as a network benefit. Such approval is for three (3) months. After three (3) months, the member must contact the claims administrator to reassess network availability; and

(C) Covered services when such services are provided in a network hospital or ambulatory surgical center and are an adjunct to a service being performed by a network provider. Examples of such adjunct services include, but are not limited to, anesthesiology, assistant surgeon, pathology, or radiology.

(5) The following services are not subject to deductible, coinsurance, or copayment requirements and will be paid at one hundred percent (100%) when provided by a network provider:

(A) Preventive care;

(B) Nutrition counseling;

(C) A newborn's initial hospitalization until discharge or transfer to another facility if the mother is a Missouri Consolidated Health Care Plan (MCHCP) member at the time of birth; and

(D) Four (4) Diabetes Self-Management Education/Training visits with a certified diabetes educator when ordered by a provider.

(6) Influenza vaccinations provided by a non-network provider will be reimbursed up to twenty-five dollars (\$25) once the member submits a receipt and a reimbursement form to the claims administrator.

(7) Married, active employees who are MCHCP subscribers and have enrolled children may meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must provide the other spouse's Social Security number (SSN) and report the other spouse as eligible for coverage when newly hired and during the open enrollment process. In the medical plan vendor and pharmacy benefit manager systems, the spouse with children enrolled will be considered the subscriber and the spouse that does not have children enrolled will be considered a dependent. If both spouses have children enrolled, the spouse with the higher Social Security number (SSN) will be considered the subscriber. Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

(8) Each subscriber will have access to payment information of the family unit only when authorization is granted by the adult covered dependent(s).

(9) Expenses toward the deductible and out-of-pocket maximum will be transferred if the member changes non-Medicare medical plans or continues enrollment under another subscriber's non-Medicare medical plan within the same plan year.

(10) Copayments. Copayments apply to network services unless otherwise specified.

(A) Office visit—primary care: twenty-five dollars (\$25); mental

health: twenty-five dollars (\$25); specialist: forty dollars (\$40); chiropractor office visit and/or manipulation: the lesser of twenty dollars (\$20) or fifty percent (50%) of the total cost of services; urgent care: fifty dollars (\$50) network and non-network. All lab, X-ray, or other medical services associated with the office visit apply to the deductible and coinsurance.

(B) Emergency room—two hundred fifty dollars (\$250) network and non-network. Deductible and coinsurance requirements apply to emergency room services in addition to the copayment. If a member is admitted to the hospital or the claims administrator considers the claim to be for a true emergency, the copayment is waived.

(C) Inpatient hospitalization—two hundred dollars (\$200) per admission for network and non-network. Deductible and coinsurance requirements apply to inpatient hospitalization services in addition to the copayment.

(11) Maximum plan payment—non-network medical claims that are not otherwise subject to a contractual discount arrangement are allowed at one hundred ten percent (110%) of Medicare reimbursement. Members may be held liable for the amount of the fee above the allowed amount.

(12) Any claim must be initially submitted within twelve (12) months following the date of service. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

(13) For a member who is an inpatient on the last calendar day of a plan year and remains an inpatient into the next plan year, the prior plan year's applicable copayment, deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

(14) Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-2.055. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as a non-network benefit. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

(15) Medicare.

(A) When MCHCP becomes aware that the member is eligible for Medicare benefits claims will be processed reflecting Medicare coverage.

(B) If a member does not enroll in Medicare when s/he is eligible and Medicare should be the member's primary plan, the member will be responsible for paying the portion Medicare would have paid. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

(C) If a Medicare primary member chooses a provider who has opted out of Medicare, the member will be responsible for paying the portion Medicare would have paid if the service was performed by a Medicare provider. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for

this plan's deductible and out-of-pocket maximum expenses.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed rule covering this same material is published in this issue of the Missouri Register.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

EMERGENCY RESCISSION

22 CSR 10-2.051 PPO 300 Plan Benefit Provisions and Covered Charges. This rule established the policy of the board of trustees in regard to the PPO 300 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded because the PPO 300 Plan will not be offered after December 31, 2018.

EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency rescission is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be filed as an emergency rescission to maintain the integrity of the current health care plan. This emergency rescission fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the Missouri Register. This emergency rescission complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rescission was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the Code of State Regulations. Emergency rescission filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed rescission covering this same material is published in this issue of the Missouri Register.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

EMERGENCY RESCISSION

22 CSR 10-2.052 PPO 600 Plan Benefit Provisions and Covered Charges. This rule established the policy of the board of trustees in regard to the PPO 600 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded because the PPO 600 Plan will not be offered after December 31, 2018.

EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency rescission is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be filed as an emergency rescission to maintain the integrity of the current health care plan. This emergency rescission fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the Missouri Register. This emergency rescission complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rescission was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. For intervening history, please consult the Code of State Regulations. Emergency rescission filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed rescission covering this same material is published in this issue of the Missouri Register.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

EMERGENCY AMENDMENT

22 CSR 10-2.053 Health Savings Account Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (1), (3), (6), (8), (10), (11), (12), (13), (17), (18), (19), and (20); and removing section (18).

PURPOSE: This amendment revises the HSA Plan deductible, out-of-pocket maximum and clarifies influenza vaccinations, diabetes self-management education/training, family deductible, access to payment information, deductible and out-of-pocket accumulations, maximum plan payments, HSA Plan eligibility, and Health Savings Account contributions when both spouses are state employees.

PURPOSE: *This rule establishes the policy of the board of trustees in regard to the Health Savings Account (HSA) Plan, benefit provisions, and covered charges of the Missouri Consolidated Health Care Plan.*

EMERGENCY STATEMENT: *This emergency amendment must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.*

(1) Deductible—per calendar year for network: per individual, one thousand six hundred fifty dollars (\$1,650); family, three thousand three hundred dollars (\$3,300) and for non-network: per individual, *[four thousand dollars (\$4,000)]* **three thousand three hundred dollars (\$3,300)**; family, *[eight thousand dollars (\$8,000)]* **six thousand six hundred dollars (\$6,600)**.

(3) Out-of-pocket maximum.

(A) The family out-of-pocket maximum applies when two (2) or more family members are covered. The family out-of-pocket maximum must be met before the plan begins to pay one hundred percent (100%) of all covered charges for any covered family member. Out-of-pocket maximums are per calendar year, as follows:

1. Network out-of-pocket maximum for individual—*[three thousand three hundred dollars (\$3,300)]* **four thousand nine hundred fifty dollars (\$4,950)**;

2. Network out-of-pocket maximum for family—*[six thousand six hundred dollars (\$6,600);]* **nine thousand nine hundred dollars (\$9,900)**. Any individual family member need only incur a maximum of seven thousand nine hundred dollars (\$7,900) before the plan begins paying one hundred percent (100%) of covered charges for that individual;

3. Non-network out-of-pocket maximum for individual—*[five thousand dollars (\$5,000)]* **nine thousand nine hundred dollars (\$9,900)**; and

4. Non-network out-of-pocket maximum for family—*[ten thousand dollars (\$10,000)]* **nineteen thousand eight hundred dollars (\$19,800)**.

(6) Influenza *[immunizations]* **vaccinations** provided by a non-network provider will be reimbursed up to twenty-five dollars (\$25) once the member submits a receipt and a reimbursement form to the claims administrator.

(8) Four (4) diabetes **self-management** education/**training** visits with a certified diabetes educator when ordered by a provider and received through a network provider are covered at one hundred percent (100%) after deductible is met.

(10) Married, active employees who are MCHCP subscribers and have enrolled children may meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must provide the other spouse's Social Security number (SSN) and report the other spouse as eligible for coverage when newly hired and during the open enrollment process. In the medical plan vendor **and pharmacy benefit manager** system, the spouse with children enrolled will be considered the subscriber and the spouse that does not have children enrolled will be considered a dependent. If both spouses have children enrolled the spouse with the higher Social Security number (SSN) will be considered the subscriber. Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

(11) Each subscriber will have access to payment information of the family unit **only when authorization is granted by the adult covered dependent(s)**.

(12) Expenses toward the deductible and out-of-pocket maximum will be transferred if the member changes **non-Medicare** medical plans or continues enrollment under another subscriber's **non-Medicare medical** plan within the same plan year.

(13) *[Usual, customary, and reasonable fee allowed]* **Maximum plan payment**—Non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed at *[the eightieth percentile of usual, customary, and reasonable fees as determined by the vendor]* **one hundred ten percent (110%) of Medicare reimbursement**. Members may be held liable for the amount of the fee above the allowed amount.

(17) An **active employee** subscriber does not qualify for the HSA Plan if s/he is claimed as a dependent on another person's tax return or, except for the plans listed in section *[(20)]* **(19)** of this rule, is covered under or enrolled in any other health plan that is not a high deductible health plan, including, but not limited to, the following types of insurance plans or programs:

[(18) If a retiree subscriber and/or his/her dependent(s) becomes eligible for Medicare in the upcoming plan year then s/he may not enroll in the HSA Plan during open enrollment.]

*[(19)]***(18)** If an **active employee** subscriber and/or his/her dependent(s) is enrolled in the HSA Plan and becomes ineligible for the HSA Plan during the plan year, the subscriber and/or his/her dependent(s) will be enrolled in the PPO *[600]* **1250** Plan. The subscriber may enroll in a different non-HSA Plan within thirty-one (31) days of

notice from MCHCP.

[[20]](19) A subscriber may qualify for this plan even if s/he is covered by any of the following:

- (A) Drug discount card;
- (B) Accident insurance;
- (C) Disability insurance;
- (D) Dental insurance;
- (E) Vision insurance; or
- (F) Long-term care insurance.

[[21]](20) Health Savings Account (HSA) Contributions.

(A) To receive contributions from MCHCP, the subscriber must be an active employee and HSA eligible as defined in the Internal Revenue Service Publication 969 on the date the contribution is made and open an HSA with the bank designated by MCHCP.

1. Subscribers who enroll in the HSA Plan during open enrollment who have a balance in a health care FSA on January 1 of the new plan year cannot receive an HSA contribution from MCHCP until after the health care FSA grace period ends March 15.

(B) A new employee or subscriber electing coverage due to a life event or loss of employer-sponsored coverage with an effective date after the MCHCP contribution will receive an applicable prorated contribution. Unless a subscriber is eligible for a special enrollment period, a subscriber will not be able to voluntarily change his/her plan selection.

(C) A subscriber who moves from subscriber-only coverage to another coverage level with an effective date after the MCHCP contribution will receive an applicable prorated contribution based on the increased level of coverage.

(D) If a subscriber moves from another coverage level to subscriber-only coverage, cancels all coverage, or MCHCP terminates coverage and has received an HSA contribution, MCHCP will not request a re-payment of the contribution.

(E) If both *[a husband and wife]* spouses are state employees covered by MCHCP and they both enroll in an HSA Plan, they must each have a separate HSA. The maximum contribution MCHCP will make for the family is six hundred dollars (\$600) regardless of the number of HSAs or the number of children covered under the HSA Plan for either parent. MCHCP will consider married state employees as one (1) family and will not make two (2) family contributions to both spouses or one (1) family contribution and one (1) individual contribution. MCHCP will make a maximum three hundred dollar (\$300) contribution to each spouse to total maximum six hundred dollars (\$600).

(F) The MCHCP contributions will be deposited into the subscriber's HSA as follows:

1. The January deposit will be made on the third Monday of the month, or the first working day after the third Monday if the third Monday is a holiday;

2. The April deposit will be made on the first Monday in April; and

3. Other deposits will be made on the first Monday of the month in which coverage is effective, or the first working day after the first Monday of the month coverage is effective if the first Monday is a state holiday.

Deposit	Subscriber Only	All other coverage levels
January	\$300.00	\$600.00
April (delayed contribution due to health care FSA grace period)	\$300.00	\$600.00
All others	A proration of \$300	A proration of \$600

AUTHORITY: sections 103.059 and 103.080.3., RSMo 2016.

Emergency rule filed Dec. 22, 2008, effective Jan. 1, 2009, expired June 29, 2009. Original rule filed Dec. 22, 2008, effective June 30, 2009. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed amendment covering this same material is published in this issue of the Missouri Register.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (1) and (3).

PURPOSE: *This amendment revises the names of the medical plans and clarifies the following benefits: dental care, diabetes education, dialysis, genetic counseling, infusions, injections, nutrition counseling, and preventive services; alphabetizes the list of medical benefits; and rennumbers as necessary.*

EMERGENCY STATEMENT: *This emergency amendment must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.*

(1) Benefit Provisions Applicable to the PPO [300] 750 Plan, PPO [600] 1250 Plan, and Health Savings Account (HSA) Plan. Subject to the plan provisions, limitations, and enrollment of the employee, the benefits are payable for covered charges incurred by a member while covered under the plans, provided the deductible requirement, if any, is met.

(3) Covered Charges Applicable to the PPO [300] 750 Plan, PPO [600] 1250, and HSA Plan.

(E) Plan benefits for the PPO [300] 750 Plan, PPO [600] 1250, and HSA Plan are as follows:

1. Allergy Testing and Immunotherapy. Allergy testing and allergy immunotherapy are considered medically necessary for members with clinically significant allergic symptoms. The following tests and treatments are covered:

A. Epicutaneous (scratch, prick, or puncture) when Immunoglobulin E- (IgE-) mediated reactions occur to any of the following:

- (I) Foods;
- (II) Hymenoptera venom (stinging insects);
- (III) Inhalants; or
- (IV) Specific drugs (penicillins and macromolecular agents);

B. Intradermal (Intracutaneous) when IgE-mediated reactions occur to any of the following:

- (I) Foods;
- (II) Hymenoptera venom (stinging insects);
- (III) Inhalants; or
- (IV) Specific drugs (penicillins and macromolecular agents);

C. Skin or Serial Endpoint Titration (SET), also known as intradermal dilutional testing (IDT), for determining the starting dose for immunotherapy for members highly allergic to any of the following:

- (I) Hymenoptera venom (stinging insects); or
- (II) Inhalants;

D. Skin Patch Testing: for diagnosing contact allergic dermatitis;

E. Photo Patch Testing: for diagnosing photo-allergy (such as photo-allergic contact dermatitis);

F. Photo Tests: for evaluating photo-sensitivity disorders;

G. Bronchial Challenge Test: for testing with methacholine, histamine, or antigens in defining asthma or airway hyperactivity when either of the following conditions is met:

- (I) Bronchial challenge test is being used to identify new allergens for which skin or blood testing has not been validated; or
- (II) Skin testing is unreliable;

H. Exercise Challenge Testing for exercise-induced bronchospasm;

I. Ingestion (Oral) Challenge Test for any of the following:

- (I) Food or other substances; or
- (II) Drugs when all of the following are met:
 - (a) History of allergy to a particular drug;
 - (b) There is no effective alternative drug; and
 - (c) Treatment with that drug class is essential;

J. In Vitro IgE Antibody Tests (RAST, MAST, FAST, ELISA, ImmunoCAP) are covered for any of the following:

- (I) Allergic broncho-pulmonary aspergillosis (ABPA) and certain parasitic diseases;
- (II) Food allergy;
- (III) Hymenoptera venom allergy (stinging insects);
- (IV) Inhalant allergy; or
- (V) Specific drugs;

K. Total Serum IgE for diagnostic evaluation in members with known or suspected ABPA and/or hyper IgE syndrome;

L. Lymphocyte transformation tests such as lymphocyte mitogen response test, PHE stimulation test, or lymphocyte antigen response assay are covered for evaluation of persons with any of the following suspected conditions:

- (I) Sensitivity to beryllium;
- (II) Congenital or acquired immunodeficiency diseases affecting cell-mediated immunity, such as severe combined immunodeficiency, common variable immunodeficiency, X-linked immunodeficiency with hyper IgM, Nijmegen breakage syndrome, reticular dysgenesis, DiGeorge syndrome, Nezelof syndrome, Wiscott-Aldrich syndrome, ataxia telangiectasia, and chronic mucocutaneous candidiasis;
- (III) Thymoma; and
- (IV) To predict allograft compatibility in the transplant setting;

M. Allergy retesting: routine allergy retesting is not considered medically necessary;

N. Allergy immunotherapy is covered for the treatment of any of the following IgE-mediated allergies:

- (I) Allergic (extrinsic) asthma;
- (II) Dust mite atopic dermatitis;
- (III) Hymenoptera (bees, hornets, wasps, fire ants) sensitive individuals;
- (IV) Mold-induced allergic rhinitis;
- (V) Perennial rhinitis;
- (VI) Seasonal allergic rhinitis or conjunctivitis when one

(1) of the following conditions are met:

- (a) Member has symptoms of allergic rhinitis or asthma after natural exposure to the allergen;
- (b) Member has a life-threatening allergy to insect stings; or

(c) Member has skin test or serologic evidence of IgE mediated antibody to a potent extract of the allergen; and

(VII) Avoidance or pharmacologic therapy cannot control allergic symptoms or member has unacceptable side effects with pharmacologic therapy;

O. Other treatments: the following other treatments are covered:

(I) Rapid, rush, cluster, or acute desensitization for members with any of the following conditions:

(a) IgE antibodies to a particular drug that cannot be treated effectively with alternative medications;

(b) Insect sting (e.g., wasps, hornets, bees, fire ants) hypersensitivity (hymenoptera); or

(c) Members with moderate to severe allergic rhinitis who need treatment during or immediately before the season of the affecting allergy;

(II) Rapid desensitization is considered experimental and investigational for other indications;

P. Epinephrine kits, to prevent anaphylactic shock for members who have had life-threatening reactions to insect stings, foods, drugs, or other allergens; have severe asthma or if needed during immunotherapy;

2. Ambulance service. The following ambulance transport services are covered:

A. By ground to the nearest appropriate facility when other means of transportation would be contraindicated;

B. By air to the nearest appropriate facility when the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate or contraindicated;

3. Applied Behavior Analysis (ABA) for Autism;

4. Bariatric surgery. Bariatric surgery is covered when all of the following requirements have been met:

A. The surgery is performed at a facility accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) for the billed procedure;

B. The following open or laparoscopic bariatric surgery procedures are covered:

(I) Roux-en-Y gastric bypass;

(II) Sleeve gastrectomy;

(III) Biliopancreatic diversion with duodenal switch for individuals with a body mass index (BMI) greater than fifty (50);

(IV) Adjustable silicone gastric banding and adjustments of a silicone gastric banding to control the rate of weight loss and/or treat symptoms secondary to gastric restriction following an adjustable silicone gastric banding procedure;

(V) Surgical reversal of bariatric surgery when complications of the original surgery (e.g., stricture, pouch dilatation, erosion, or band slippage) cause abdominal pain, inability to eat or drink, or cause vomiting of prescribed meals;

(VI) Revision of a previous bariatric surgical procedure or conversion to another procedure due to inadequate weight loss when one (1) of the following specific criteria has been met:

(a) There is evidence of full compliance with the previously prescribed post-operative dietary and exercise program; or

(b) There is documented clinical testing demonstrating technical failure of the original bariatric surgical procedure which caused the individual to fail achieving adequate weight loss of at least fifty percent (50%) of excess body weight or failure to achieve body weight to within thirty percent (30%) of ideal body weight at least two (2) years following the original surgery;

C. All of the following criteria have been met:

(I) The member is eighteen (18) years or older or has reached full skeletal growth, and has evidence of one (1) of the following:

(a) BMI greater than forty (40); or

(b) BMI between thirty-five (35) and thirty-nine and nine tenths (39.9) and one (1) or more of the following:

I. Type II diabetes;

II. Cardiovascular disease such as stroke, myocardial infarction, stable or unstable angina pectoris, hypertension, or coronary artery bypass; or

III. Life-threatening cardiopulmonary problems such as severe sleep apnea, Pickwickian syndrome, or obesity-related cardiomyopathy; and

(II) Demonstration that dietary attempts at weight control have been ineffective through completion of a structured diet program. Commercial weight loss programs are acceptable if completed under the direction of a provider or registered dietitian and documentation of participation is available for review. One (1) structured diet program for six (6) consecutive months or two (2) structured diet programs for three (3) consecutive months each within a two- (2-) year period prior to the request for the surgical treatment of morbid obesity are sufficient. Provider-supervised programs consisting exclusively of pharmacological management are not sufficient; and

(III) A thorough multidisciplinary evaluation within the previous twelve (12) months, which include all of the following:

(a) An evaluation by a bariatric surgeon recommending surgical treatment, including a description of the proposed procedure and all of the associated current procedural terminology codes;

(b) A separate medical evaluation from a provider other than the surgeon recommending surgery that includes a medical clearance for bariatric surgery;

(c) Completion of a psychological examination from a mental health provider evaluating the member's readiness and fitness for surgery and the necessary post-operative lifestyle changes. After the evaluation, the mental health provider must provide clearance for bariatric surgery; and

(d) A nutritional evaluation by a provider or registered dietitian;

5. Blood storage. Storage of whole blood, blood plasma, and blood products is covered in conjunction with medical treatment that requires immediate blood transfusion support;

/5./6. Bone Growth Stimulators. Implantable bone growth stimulators are covered as an outpatient surgery benefit. The following nonimplantable bone growth stimulators are covered as a durable medical equipment benefit:

A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)) to accelerate healing of fresh fractures, fusions, or delayed unions at either of the following high-risk sites:

(I) Fresh fractures, fusions, or delayed unions of the shaft (diaphysis) of the tibia that are open or segmental; or

(II) Fresh fractures, fusions, or delayed unions of the scaphoid (carpal navicular);

B. Ultrasonic osteogenesis stimulator for non-unions, failed arthrodesis, and congenital pseudarthrosis (pseudoarthrosis) of the appendicular skeleton if there has been no progression of healing for three (3) or more months despite appropriate fracture care; or

C. Direct current electrical bone-growth stimulator is covered for the following indications:

(I) Delayed unions of fractures or failed arthrodesis at high-risk sites (i.e., open or segmental tibial fractures, carpal navicular fractures);

(II) Non-unions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three (3) or more months despite appropriate fracture care; or

(III) Members who are at high risk for spinal fusion failure when any of the following criteria is met:

(a) A multiple-level fusion entailing three (3) or more vertebrae (e.g., L3 to L5, L4 to S1, etc.);

(b) Grade II or worse spondylolisthesis; or

(c) One (1) or more failed fusions;

/6./7. Contraception and Sterilization. All Food and Drug Administration- (FDA-) approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity;

/7. Blood storage. Storage of whole blood, blood plasma, and blood products is covered in conjunction with medical treatment that requires immediate blood transfusion support;]

8. Cardiac rehabilitation. An electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) is covered for specific criteria when it is individually prescribed by a provider and a formal exercise stress test is completed following the event and prior to the initiation of the program. Cardiac rehabilitation is covered for members who meet one (1) of the following criteria:

A. Acute myocardial infarction (MI) (heart attack in the last twelve (12) months);

B. Coronary artery bypass grafting (CABG);

C. Stable angina pectoris;

D. Percutaneous coronary vessel remodeling;

E. Valve replacement or repair;

F. Heart transplant;

G. Coronary artery disease (CAD) associated with chronic stable angina that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities; or

H. Heart failure that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities;

9. Chelation therapy. The administration of FDA-approved chelating agents is covered for any of the following conditions:

A. Genetic or hereditary hemochromatosis;

B. Lead overload in cases of acute or long-term lead exposure;

C. Secondary hemochromatosis due to chronic iron overload due to transfusion-dependent anemias (e.g., Thalassemias, Cooley's anemia, sickle cell anemia, sideroblastic anemia);

D. Copper overload in patients with Wilson's disease;

E. Arsenic, mercury, iron, copper, or gold poisoning when long-term exposure to and toxicity has been confirmed through lab results or clinical findings consistent with metal toxicity;

F. Aluminum overload in chronic hemodialysis patients;

G. Emergency treatment of hypercalcemia;

H. Prophylaxis against doxorubicin-induced cardiomyopathy;

I. Internal plutonium, americium, or curium contamination;

or

J. Cystinuria;

10. Chiropractic services. Chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) are covered when all of the following conditions are met:

A. A neuromusculoskeletal condition is diagnosed that may be relieved by standard chiropractic treatment in order to restore optimal function;

B. Chiropractic care is being performed by a licensed doctor of chiropractic who is practicing within the scope of his/her license as defined by state law;

C. The individual is involved in a treatment program that clearly documents all of the following:

(I) A prescribed treatment program that is expected to

result in significant therapeutic improvement over a clearly defined period of time;

(II) The symptoms being treated;

(III) Diagnostic procedures and results;

(IV) Frequency, duration, and results of planned treatment modalities;

(V) Anticipated length of treatment plan with identification of quantifiable, attainable short-term and long-term goals; and

(VI) Demonstrated progress toward significant functional gains and/or improved activity tolerances;

D. Following previous successful treatment with chiropractic care, acute exacerbation or re-injury are covered when all of the following criteria are met:

(I) The member reached maximal therapeutic benefit with prior chiropractic treatment;

(II) The member was compliant with a self-directed home-care program;

(III) Significant therapeutic improvement is expected with continued treatment; and

(IV) The anticipated length of treatment is expected to be short-term (e.g., no more than six (6) visits within a three- (3-) week period);

11. Clinical trials. Routine member care costs incurred as the result of a Phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition are covered when—

A. The study or investigation is conducted under an investigational new drug application reviewed by the FDA; or

B. Is a drug trial that is exempt from having such an investigational new drug application. Life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted; and

C. Routine member care costs include all items and services consistent with the coverage provided in plan benefits that would otherwise be covered for a member not enrolled in a clinical trial. Routine patient care costs do not include the investigational item, device, or service itself; items and services that are provided solely to satisfy data collection and analysis needs and are not used in the direct clinical management of the member; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

D. The member must be eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

E. The clinical trial must be approved or funded by one (1) of the following:

(I) National Institutes of Health (NIH);

(II) Centers for Disease Control and Prevention (CDC);

(III) Agency for Health Care Research and Quality;

(IV) Centers for Medicare & Medicaid Services (CMS);

(V) A cooperative group or center of any of the previously named agencies or the Department of Defense or the Department of Veterans Affairs;

(VI) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

(VII) A study or investigation that is conducted by the Department of Veterans Affairs, the Department of Defense, or the Department of Energy and has been reviewed and approved to be comparable to the system of peer review of studies and investigations used by the NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

12. Cochlear implant device. Uniaural (monaural) or binaural (bilateral) cochlear implantation and necessary replacement batteries are covered for a member with bilateral, pre- or post-linguistic, sensorineural, moderate-to-profound hearing impairment when there is reasonable expectation that a significant benefit will be achieved from the device and when the following age-specific criteria are met:

A. Auditory brainstem implant. Auditory brainstem implant (ABI) covered for the diagnosis of neurofibromatosis type II, von Recklinghausen's disease, or when a member is undergoing bilateral removal of tumors of the auditory nerves, and it is anticipated that the member will become completely deaf as a result of the surgery, or the member had bilateral auditory nerve tumors removed and is now bilaterally deaf;

(I) For an adult (age eighteen (18) years or older) with BOTH of the following:

(a) Bilateral, severe to profound sensorineural hearing loss determined by a pure-tone average of seventy (70) decibels (dB) hearing loss or greater at five hundred (500) hertz (Hz), one thousand (1000) Hz, and two thousand (2000) Hz; and

(b) Member has limited benefit from appropriately fitted binaural hearing aids. Limited benefit from amplification is defined by test scores of forty percent (40%) correct or less in best-aided listening condition on open-set sentence cognition (e.g., Central Institute for the Deaf (CID) sentences, Hearing in Noise Test (HINT) sentences, and Consonant-Nucleus-Consonant (CNC) test);

(II) For a child age twelve (12) months to seventeen (17) years, eleven (11) months with both of the following:

(a) Profound, bilateral sensorineural hearing loss with thresholds of ninety (90) dB or greater at one thousand (1000) Hz; and

(b) Limited or no benefit from a three- (3-) month trial of appropriately fitted binaural hearing aids;

(III) For children four (4) years of age or younger, with one (1) of the following:

(a) Failure to reach developmentally appropriate auditory milestones measured using the Infant-Toddler Meaningful Auditory Integration Scale, the Meaningful Auditory Integration Scale, or the Early Speech Perception test; or

(b) Less than twenty percent (20%) correct on open-set word recognition test Multisyllabic Lexical Neighborhood Test (MLNT) in conjunction with appropriate amplification and participation in intensive aural habilitation over a three- (3-) to six- (6-) month period;

(IV) For children older than four (4) years of age with one (1) of the following:

(a) Less than twelve percent (12%) correct on the Phonetically Balanced-Kindergarten Test; or

(b) Less than thirty percent (30%) correct on the HINT for children, the open-set Multisyllabic Lexical Neighborhood Test (MLNT) or Lexical Neighborhood Test (LNT), depending on the child's cognitive ability and linguistic skills; and

(V) A three- (3-) to six- (6-) month hearing aid trial has been undertaken by a child without previous experience with hearing aids;

B. Radiologic evidence of cochlear ossification;

C. The following additional medical necessity criteria must also be met for uniaural (monaural) or binaural (bilateral) cochlear implantation in adults and children:

(I) Member must be enrolled in an educational program that supports listening and speaking with aided hearing;

(II) Member must have had an assessment by an audiologist and from an otolaryngologist experienced in this procedure indicating the likelihood of success with this device;

(III) Member must have no medical contraindications to cochlear implantation (e.g., cochlear aplasia, active middle ear infection); and

(IV) Member must have arrangements for appropriate follow-up care, including the speech therapy required to take full advantage of this device;

D. A second cochlear implant is covered in the contralateral (opposite) ear as medically necessary in an individual with an existing unilateral cochlear implant when the hearing aid in the contralateral ear produces limited or no benefit;

E. The replacement of an existing cochlear implant is covered when either of the following criteria is met:

(I) Currently used component is no longer functional and cannot be repaired; or

(II) Currently used component renders the implant recipient unable to adequately and/or safely perform his/her age-appropriate activities of daily living; and

F. Post-cochlear or ABI rehabilitation program (aural rehabilitation) is covered to achieve benefit from a covered device;

13. Dental care.

A. Dental care is covered for the following:

(I) Treatment to reduce trauma and restorative services limited to dental implants only when the result of accidental injury to sound natural teeth and tissue that are viable, functional, and free of disease. **Treatment must be initiated within sixty (60) days of accident;** and

(II) Restorative services limited to dental implants when needed as a result of cancerous or non-cancerous tumors and cysts, cancer, and post-surgical sequelae.

B. The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization when provided in a network or non-network hospital or surgical center;

14. Diabetes **self-management training**/E/education when prescribed by a provider and taught by a Certified Diabetes Educator through a medical network provider;

15. Dialysis is covered when received through a network provider;

/15./16. Durable medical equipment (DME) is covered when ordered by a provider to treat an injury or illness. DME includes, but is not limited to, the following:

A. Insulin pumps;

B. Oxygen;

C. Augmentative communication devices;

D. Manual and powered mobility devices;

E. Disposable supplies that do not withstand prolonged use and are periodically replaced, including, but not limited to, the following:

(I) Colostomy and ureterostomy bags;

(II) Prescription compression stockings limited to two (2) pairs or four (4) individual stockings per plan year;

F. Blood pressure cuffs/monitors with a diagnosis of diabetes;

G. Repair and replacement of DME is covered when any of the following criteria are met:

(I) Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

(II) Routine wear and tear of the equipment renders it non-functional and the member still requires the equipment; or

(III) The provider has documented that the condition of the member changes or if growth-related;

/16./17. Emergency room services. Coverage is for emergency medical conditions. If a member is admitted to the hospital, s/he may be required to transfer to network facility for maximum benefit. Hospital and ancillary charges are paid as a network benefit;

/17./18. Eye glasses and contact lenses. Coverage limited to charges incurred in connection with the fitting of eye glasses or contact lenses for initial placement within one (1) year following cataract surgery;

/18./19. Foot care (trimming of nails, corns, or calluses). Foot care services are covered when administered by a provider and—

A. When associated with systemic conditions that are significant enough to result in severe circulatory insufficiency or areas of desensitization in the lower extremities including, but not limited to, any of the following:

(I) Diabetes mellitus;

(II) Peripheral vascular disease; or

(III) Peripheral neuropathy.

(IV) Evaluation/debridement of mycotic nails, in the absence of a systemic condition, when both of the following conditions are met:

(a) Pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate; and

(b) If the member is ambulatory, pain markedly limits ambulation;

/19./20. Genetic counseling. Pre-test and post-test genetic counseling with a provider or a licensed or certified genetic counselor are covered when a member is recommended for covered heritable genetic testing.

A. Genetic counseling in connection with pregnancy management is covered only for evaluation of any of the following:

(I) Couples who are closely related genetically (e.g., consanguinity, incest);

(II) Familial cancer disorders;

(III) Individuals recognized to be at increased risk for genetic disorders;

(IV) Infertility cases where either parent is known to have a chromosomal abnormality;

(V) Primary amenorrhea, azoospermia, abnormal sexual development, or failure in developing secondary sexual characteristics;

(VI) Mother is a known, or presumed carrier of an X linked recessive disorder;

(VII) One (1) or both parents are known carriers of an autosomal recessive disorder;

(VIII) Parents of a child born with a genetic disorder, birth defect, inborn error of metabolism, or chromosome abnormality;

(IX) Parents of a child with intellectual developmental disorders, autism, developmental delays, or learning disabilities;

(X) Pregnant women who, based on prenatal ultrasound tests or an abnormal multiple marker screening test, maternal serum alpha-fetoprotein (AFP) test, test for sickle cell anemia, or tests for other genetic abnormalities have been told their pregnancy may be at increased risk for complications or birth defects;

(XI) Pregnant women age thirty-five (35) years or older at delivery;

(XII) Pregnant women, or women planning pregnancy, exposed to potentially teratogenic, mutagenic, or carcinogenic agents such as chemicals, drugs, infections, or radiation;

(XIII) Previous unexplained stillbirth or repeated (three (3) or more; two (2) or more among infertile couples) first-trimester miscarriages, where there is suspicion of parental or fetal chromosomal abnormalities; or

(XIV) When contemplating pregnancy, either parent affected with an autosomal dominant disorder;

/20./21. Genetic testing.

A. Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following criteria are met:

(I) The member displays clinical features or is at direct risk of inheriting the mutation in question (pre-symptomatic);

(II) The result of the test will directly impact the treatment being delivered to the member;

(III) The testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and

(IV) After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain;/.

B. Genetic testing for the breast cancer susceptibility gene (BRCA) when family history is present;

/21./22. Hair analysis. Chemical hair analysis is covered for the diagnosis of suspected chronic arsenic poisoning. Other purposes are considered experimental and investigational;

/22./23. Hair prostheses. Prostheses and expenses for scalp hair prostheses worn for hair loss are covered for alopecia areata or alopecia totalis for children eighteen (18) years of age or younger. The annual maximum is two hundred dollars (\$200), and the lifetime maximum is three thousand two hundred dollars (\$3,200);

/23./24. Hearing aids (per ear). Hearing aids covered for conductive hearing loss unresponsive to medical or surgical interventions,

sensorineural hearing loss, and mixed hearing loss.

A. Prior to receiving a hearing aid members must receive—

(I) A medical exam by a physician or other qualified provider to identify any medically treatable conditions that may affect hearing; and

(II) A comprehensive hearing test to assess the need for hearing aids conducted by a certified audiologist, hearing instrument specialist, or other provider licensed or certified to administer this test.

B. Covered once every two (2) years. If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

(I) Conventional: one thousand dollars (\$1,000).

(II) Programmable: two thousand dollars (\$2,000).

(III) Digital: two thousand five hundred dollars (\$2,500).

(IV) Bone Anchoring Hearing Aid (BAHA): three thousand five hundred dollars (\$3,500);

[24.]25. Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by provider;

[25.]26. Home health care. Skilled home health nursing care is covered for members who are homebound because of injury or illness (i.e., the member leaves home only with considerable and taxing effort, and absences from home are infrequent or of short duration, or to receive medical care). Services must be performed by a registered nurse or licensed practical nurse, licensed therapist, or a registered dietitian. Covered services include:

A. Home visits instead of visits to the provider's office that do not exceed the usual and customary charge to perform the same service in a provider's office;

B. Intermittent nurse services. Benefits are paid for only one (1) nurse at any one (1) time, not to exceed four (4) hours per twenty-four- (24-) hour period;

C. Nutrition counseling provided by or under the supervision of a registered dietitian;

D. Physical, occupational, respiratory, and speech therapy provided by or under the supervision of a licensed therapist;

E. Medical supplies, drugs, or medication prescribed by provider, and laboratory services to the extent that the plan would have covered them under this plan if the covered person had been in a hospital;

F. A home health care visit is defined as—

(I) A visit by a nurse providing intermittent nurse services (each visit includes up to a four- (4-) hour consecutive visit in a twenty-four- (24-) hour period if clinical eligibility for coverage is met) or a single visit by a therapist or a registered dietitian; and

G. Benefits cannot be provided for any of the following:

(I) Homemaker or housekeeping services;

(II) Supportive environment materials such as handrails, ramps, air conditioners, and telephones;

(III) Services performed by family members or volunteer workers;

(IV) "Meals on Wheels" or similar food service;

(V) Separate charges for records, reports, or transportation;

(VI) Expenses for the normal necessities of living such as food, clothing, and household supplies; and

(VII) Legal and financial counseling services, unless otherwise covered under this plan;

[26.]27. Hospice care and palliative services (inpatient or outpatient). Includes bereavement and respite care. Hospice care services, including pre-hospice evaluation or consultation, are covered when the individual is terminally ill and expected to live six (6) months or less, potentially curative treatment for the terminal illness is not part of the prescribed plan of care, the individual or appointed designee has formally consented to hospice care (i.e., care directed mostly toward palliative care and symptom management), and the hospice services are provided by a certified/accredited hospice agency with care available twenty-four (24) hours per day, seven (7) days per week.

A. When the above criteria are met, the following hospice care services are covered:

(I) Assessment of the medical and social needs of the terminally ill person, and a description of the care to meet those needs;

(II) Inpatient care in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy, and part-time home health care services;

(III) Outpatient care for other services as related to the terminal illness, which include services of a physician, physical or occupational therapy, and nutrition counseling provided by or under the supervision of a registered dietitian; and

(IV) Bereavement counseling benefits which are received by a member's close relative when directly connected to the member's death and bundled with other hospice charges. The services must be furnished within twelve (12) months of death;

[27.]28. Hospital (includes inpatient, outpatient, and surgical centers).

A. The following benefits are covered:

(I) Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a covered expense only when clinical eligibility for coverage is met. If the hospital has no semi-private rooms, the plan will allow the private room rate subject to usual, customary, and reasonable charges or the network rate, whichever is applicable;

(II) Intensive care unit room and board;

(III) Surgery, therapies, and ancillary services including, but not limited to:

(a) Cornea transplant;

(b) Coverage for breast reconstruction surgery or prostheses following mastectomy and lumpectomy is available to both females and males. A diagnosis of breast cancer is not required for breast reconstruction services to be covered, and the timing of reconstructive services is not a factor in coverage;

(c) Sterilization for the purpose of birth control is covered;

(d) Cosmetic/reconstructive surgery is covered to repair a functional disorder caused by disease or injury;

(e) Cosmetic/reconstructive surgery is covered to repair a congenital defect or abnormality for a member younger than nineteen (19) years; and

(f) Blood, blood plasma, and plasma expanders are covered, when not available without charge;

(IV) Inpatient mental health services are covered when authorized by a physician for treatment of a mental health disorder. Inpatient mental health services are covered, subject to all of the following:

(a) Member must be ill in more than one (1) area of daily living to such an extent that s/he is rendered dysfunctional and requires the intensity of an inpatient setting for treatment. Without such inpatient treatment, the member's condition would deteriorate;

(b) The member's mental health disorder must be treatable in an inpatient facility;

(c) The member's mental health disorder must meet diagnostic criteria as described in the most recent edition of the *American Psychiatric Association Diagnostic and Statistical Manual (DSM)*. If outside of the United States, the member's mental health disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region;

(d) The attending provider must be a psychiatrist. If the admitting provider is not a psychiatrist, a psychiatrist must be attending to the member within twenty-four (24) hours of admittance. Such psychiatrist must be United States board-eligible or board-certified. If outside of the United States, inpatient services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending provider must meet the requirements, if any, set out by the foreign government or regionally-recognized

licensing body for treatment of mental health disorders;

(e) Day treatment (partial hospitalization) for mental health services means a day treatment program that offers intensive, multidisciplinary services provided on less than a full-time basis. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such programs must be a less-restrictive alternative to inpatient treatment; and

(f) Mental health services received in a residential treatment facility that is licensed by the state in which it operates and provides treatment for mental health disorders is covered. This does not include services provided at a group home. If outside of the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and

(V) Outpatient mental health services are covered if the member is at a therapeutic medical or mental health facility and treatment includes measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident. Treatment must be provided by one (1) of the following:

(a) A United States board-eligible or board-certified psychiatrist licensed in the state where the treatment is provided;

(b) A therapist with a doctorate or master's degree that denotes a specialty in psychiatry (Psy.D.);

(c) A state-licensed psychologist;

(d) A state-licensed or certified social worker practicing within the scope of his or her license or certification; or

(e) Licensed professional counselor;

29. Infusions are covered when received through a network provider. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered are not a medical plan benefit but are covered as part of the pharmacy benefit;

[28.]30. Injections [and infusions. Injections and infusions are covered]. See preventive services for coverage of *[immunizations/ vaccinations]*. See contraception and sterilization for coverage of birth control injections. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered~~[, including injectables,]~~ are not a medical plan benefit but are covered as part of the pharmacy benefit.

A. B12 injections are covered for the following conditions:

(I) Pernicious anemia;

(II) Crohn's disease;

(III) Ulcerative colitis;

(IV) Inflammatory bowel disease;

(V) Intestinal malabsorption;

(VI) Fish tapeworm anemia;

(VII) Vitamin B12 deficiency;

(VIII) Other vitamin B12 deficiency anemia;

(IX) Macrocytic anemia;

(X) Other specified megaloblastic anemias;

(XI) Megaloblastic anemia;

(XII) Malnutrition of alcoholism;

(XIII) Thrombocytopenia, unspecified;

(XIV) Dementia in conditions classified elsewhere;

(XV) Polyneuropathy in diseases classified elsewhere;

(XVI) Alcoholic polyneuropathy;

(XVII) Regional enteritis of small intestine;

(XVIII) Postgastric surgery syndromes;

(XIX) Other prophylactic chemo-therapy;

(XX) Intestinal bypass or anastomosis status;

(XXI) Acquired absence of stomach;

(XXII) Pancreatic insufficiency; and

(XXIII) Ideopathic progressive polyneuropathy;

[29.]31. Lab, X-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition. Professional charges for automated lab services performed by

an out-of-network provider are not covered;

[30.]32. Maternity coverage. Prenatal and postnatal care is covered. Routine prenatal office visits and screenings recommended by the Health Resources and Services Administration are covered at one hundred percent (100%). Other care is subject to the deductible and coinsurance. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after vaginal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post discharge care that shall consist of a two- (2-) visit minimum, at least one (1) in the home;

[31.]33. Nutritional counseling. Individualized nutritional evaluation and counseling for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program is covered when ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian);

[32.]34. Nutrition therapy.

A. Nutrition therapy is covered only when the following criteria are met:

(I) Nutrition therapy is the sole source of nutrients or a significant percentage of the daily caloric intake;

(II) Nutrition therapy is used in the treatment of, or in association with, a demonstrable disease, condition, or disorder;

(III) Nutrition therapy is necessary to sustain life or health;

(IV) Nutrition therapy is prescribed by a provider; and

(V) Nutrition therapy is managed, monitored, and evaluated on an on-going basis, by a provider.

B. Only the following types of nutrition therapy are covered:

(I) Enteral Nutrition (EN). EN is the provision of nutritional requirements via the gastrointestinal tract. EN can be taken orally or through a tube into the stomach or small intestine;

(II) Parenteral Nutrition Therapy (PN) and Total Parenteral Nutrition (TPN). PN is liquid nutrition administered through a vein to provide part of daily nutritional requirements. TPN is a type of PN that provides all daily nutrient needs. PN or TPN are covered when the member's nutritional status cannot be adequately maintained on oral or enteral feedings;

(III) Intradialytic Parenteral Nutrition (IDPN). IDPN is a type of PN that is administered to members on chronic hemodialysis during dialysis sessions to provide most nutrient needs. IDPN is covered when the member is on chronic hemodialysis and nutritional status cannot be adequately maintained on oral or enteral feedings;

[33.]35. Office visit. Member encounter with a provider for health care, mental health, or substance use disorder in an office, clinic, or ambulatory care facility is covered based on the service, procedure, or related treatment plan;

[34.]36. Oral surgery is covered for injury, tumors, or cysts. Oral surgery includes, but is not limited to, reduction of fractures and dislocation of the jaws; external incision and drainage of cellulites; incision of accessory sinuses, salivary glands, or ducts; excision of exostosis of jaws and hard palate; and frenectomy. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. Extractions of bony or partial bony impactions are excluded;

[35.]37. Orthognathic or Jaw Surgery. Orthognathic or jaw surgery is covered when one (1) of the following conditions is documented and diagnosed:

A. Acute traumatic injury, and post-surgical sequela;

B. Cancerous or non-cancerous tumors and cysts, cancer, and post-surgical sequela;

C. Cleft lip/palate (for cleft lip/palate related jaw surgery); or

D. Physical or physiological abnormality when one (1) of the following criteria is met:

(I) Anteroposterior Discrepancies—

(a) Maxillary/Mandibular incisor relationship: over jet of 5mm or more, or a 0 to a negative value (norm 2mm);

(b) Maxillary/Mandibular anteroposterior molar relationship discrepancy of 4mm or more (norm 0 to 1mm); or

(c) These values represent two (2) or more standard deviation from published norms;

(II) Vertical Discrepancies—

(a) Presence of a vertical facial skeletal deformity which is two (2) or more standard deviations from published norms for accepted skeletal landmarks;

(b) Open bite with no vertical overlap of anterior teeth or unilateral or bilateral posterior open bite greater than 2mm;

(c) Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch; or

(d) Supraeruption of a dentoalveolar segment due to lack of occlusion;

(III) Transverse Discrepancies—

(a) Presence of a transverse skeletal discrepancy which is two (2) or more standard deviations from published norms; or

(b) Total bilateral maxillary palatal cusp to mandibular-fossa discrepancy of 4mm or greater, or a unilateral discrepancy of 3mm or greater, given normal axial inclination of the posterior teeth; or

(IV) Asymmetries—

(a) Anteroposterior, transverse, or lateral asymmetries greater than 3mm with concomitant occlusal asymmetry;

(V) Masticatory (chewing) and swallowing dysfunction due to malocclusion (e.g., inability to incise or chew solid foods, choking on incompletely masticated solid foods, damage to soft tissue during mastication, malnutrition);

(VI) Speech impairment; or

(VII) Obstructive sleep apnea or airway dysfunction;

[36.]38. Orthotics.

A. Ankle-Foot Orthosis (AFO) and Knee-Ankle-Foot Orthosis (KAFO).

(I) Basic coverage criteria for AFO and KAFO used during ambulation are as follows:

(a) AFO is covered when used in ambulation for members with weakness or deformity of the foot and ankle, which require stabilization for medical reasons, and have the potential to benefit functionally;

(b) KAFO is covered when used in ambulation for members when the following criteria are met:

I. Member is covered for AFO; and

II. Additional knee stability is required; and

(c) AFO and KAFO that are molded-to-patient-model, or custom-fabricated, are covered when used in ambulation, only when the basic coverage criteria and one (1) of the following criteria are met:

I. The member could not be fitted with a prefabricated AFO;

II. AFO or KAFO is expected to be permanent or for more than six (6) months duration;

III. Knee, ankle, or foot must be controlled in more than one (1) plane;

IV. There is documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or

V. The member has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

(II) AFO and KAFO Not Used During Ambulation.

(a) AFO and KAFO not used in ambulation are covered if the following criteria are met:

I. Passive range of motion test was measured with goniometer and documented in the medical record;

II. Documentation of an appropriate stretching program administered under the care of provider or caregiver;

III. Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least ten degrees (10°) (i.e., a non-fixed contracture);

IV. Reasonable expectation of the ability to correct the contracture;

V. Contracture is interfering or expected to interfere

significantly with the patient's functional abilities; and

VI. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons; or

VII. Member has plantar fasciitis.

(b) Replacement interface for AFO or KAFO is covered only if member continues to meet coverage criteria and is limited to a maximum of one (1) per six (6) months.

B. Cast Boot, Post-Operative Sandal or Shoe, or Healing Shoe. A cast boot, post-operative sandal or shoe, or healing shoe is covered for one (1) of the following indications:

(I) To protect a cast from damage during weight-bearing activities following injury or surgery;

(II) To provide appropriate support and/or weight-bearing surface to a foot following surgery;

(III) To promote good wound care and/or healing via appropriate weight distribution and foot protection; or

(IV) When the patient is currently receiving treatment for lymphedema and the foot cannot be fitted into conventional footwear.

C. Cranial Orthoses. Cranial orthosis is covered for Synostotic and Non-Synostotic Plagiocephaly. Plagiocephaly is an asymmetrically shaped head. Synostotic Plagiocephaly is due to premature closure of cranial sutures. Non-Synostotic Plagiocephaly is from positioning or deformation of the head. Cranial orthosis is the use of a special helmet or band on the head which aids in molding the shape of the cranium to normal. Initial reimbursement shall cover any subsequent revisions.

D. Elastic Supports. Elastic supports are covered when prescribed for one (1) of the following indications:

(I) Severe or incapacitating vascular problems, such as acute thrombophlebitis, massive venous stasis, or pulmonary embolism;

(II) Venous insufficiency;

(III) Varicose veins;

(IV) Edema of lower extremities;

(V) Edema during pregnancy; or

(VI) Lymphedema.

E. Footwear Incorporated Into a Brace for Members with Skeletally Mature Feet. Footwear incorporated into a brace must be billed by the same supplier billing for the brace. The following types of footwear incorporated into a brace are covered:

(I) Orthopedic footwear;

(II) Other footwear such as high top, depth inlay, or custom;

(III) Heel replacements, sole replacements, and shoe transfers involving shoes on a brace;

(IV) Inserts for a shoe that is an integral part of a brace and are required for the proper functioning of the brace; or

(V) Other shoe modifications if they are on a shoe that is an integral part of a brace and are required for the proper functioning of the brace.

F. Foot Orthoses. Custom, removable foot orthoses are covered for members who meet the following criteria:

(I) Member with skeletally mature feet who has any of the following conditions:

(a) Acute plantar fasciitis;

(b) Acute sport-related injuries with diagnoses related to inflammatory problems such as bursitis or tendonitis;

(c) Calcaneal bursitis (acute or chronic);

(d) Calcaneal spurs (heel spurs);

(e) Conditions related to diabetes;

(f) Inflammatory conditions (e.g., sesamoiditis, submetatarsal bursitis, synovitis, tenosynovitis, synovial cyst, osteomyelitis, and plantar fascial fibromatosis);

(g) Medial osteoarthritis of the knee;

(h) Musculoskeletal/arthropathic deformities including deformities of the joint or skeleton that impairs walking in a normal shoe (e.g., bunions, hallux valgus, talipes deformities, pes deformities, or anomalies of toes);

(i) Neurologically impaired feet including neuroma,

tarsal tunnel syndrome, ganglionic cyst;

(j) Neuropathies involving the feet, including those associated with peripheral vascular disease, diabetes, carcinoma, drugs, toxins, and chronic renal disease; or

(k) Vascular conditions including ulceration, poor circulation, peripheral vascular disease, Buerger's disease (thromboangiitis obliterans), and chronic thrombophlebitis;

(II) Member with skeletally immature feet who has any of the following conditions:

(a) Hallux valgus deformities;

(b) In-toe or out-toe gait;

(c) Musculoskeletal weakness such as pronation or pes planus;

(d) Structural deformities such as tarsal coalitions; or

(e) Torsional conditions such as metatarsus adductus, tibial torsion, or femoral torsion.

G. Helmets. Helmets are covered when cranial protection is required due to a documented medical condition that makes the member susceptible to injury during activities of daily living.

H. Hip Orthosis. Hip orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the hip;

(II) To facilitate healing following an injury to the hip or related soft tissues;

(III) To facilitate healing following a surgical procedure of the hip or related soft tissue; or

(IV) To otherwise support weak hip muscles or a hip deformity.

I. Knee Orthosis. Knee orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the knee;

(II) To facilitate healing following an injury to the knee or related soft tissues;

(III) To facilitate healing following a surgical procedure on the knee or related soft tissue; or

(IV) To otherwise support weak knee muscles or a knee deformity.

J. Orthopedic Footwear for Diabetic Members.

(I) Orthopedic footwear, therapeutic shoes, inserts, or modifications to therapeutic shoes are covered for diabetic members if any following criteria are met:

(a) Previous amputation of the other foot or part of either foot;

(b) History of previous foot ulceration of either foot;

(c) History of pre-ulcerative calluses of either foot;

(d) Peripheral neuropathy with evidence of callus formation of either foot;

(e) Foot deformity of either foot; or

(f) Poor circulation in either foot.

(II) Coverage is limited to one (1) of the following within one (1) year:

(a) One (1) pair of custom molded shoes (which includes inserts provided with these shoes) and two (2) additional pairs of inserts;

(b) One (1) pair of depth shoes and three (3) pairs of inserts (not including the non-customized removable inserts provided with such shoes); or

(c) Up to three (3) pairs of inserts not dispensed with diabetic shoes if the supplier of the shoes verifies in writing that the patient has appropriate footwear into which the insert can be placed.

K. Orthotic-Related Supplies. Orthotic-related supplies are covered when necessary for the function of the covered orthotic device.

L. Spinal Orthoses. A thoracic-lumbar-sacral orthosis, lumbar orthosis, lumbar-sacral orthosis, and cervical orthosis are covered for the following indications:

(I) To reduce pain by restricting mobility of the trunk;

(II) To facilitate healing following an injury to the spine or related soft tissues;

(III) To facilitate healing following a surgical procedure of the spine or related soft tissue; or

(IV) To otherwise support weak spinal muscles or a deformed spine.

M. Trusses. Trusses are covered when a hernia is reducible with the application of a truss.

N. Upper Limb Orthosis. Upper limb orthosis is covered for the following indications:

(I) To reduce pain by restricting mobility of the joint(s);

(II) To facilitate healing following an injury to the joint(s) or related soft tissues; or

(III) To facilitate healing following a surgical procedure of the joint(s) or related soft tissue.

O. Orthotic Device Replacement. When repairing an item that is no longer cost-effective and is out of warranty, the plan will consider replacing the item subject to review of medical necessity and life expectancy of the device;

[37.]39. Preventive services.

A. Services recommended by the U.S. Preventive Services Task Force (categories A and B).

B. *[Immunizations]* **Vaccinations** recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

C. Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration.

D. Preventive care and screenings for women supported by the Health Resources and Services Administration.

E. Preventive exams and other services ordered as part of the exam. For benefits to be covered as preventive, *[including X-rays and lab services,]* they must be coded by the provider as routine, without indication of an injury or illness.

F. Cancer screenings. One (1) per calendar year. Additional screenings beyond one (1) per calendar year covered as diagnostic unless otherwise specified—

(I) Mammograms—no age limit. Standard two-dimensional (2D) breast mammography and breast tomosynthesis (three-dimensional (3D) mammography);

(II) Pap smears—no age limit;

(III) Prostate—no age limit; and

(IV) Colorectal screening—no age limit.

G. *[Zoster vaccination (shingles)]—The zoster vaccine is covered for members age fifty (50) years and older* **Online weight management program offered through the plan's exclusive provider arrangement;**

[38.]40. Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement is covered due to normal wear and tear, if there is a change in medical condition, or if growth-related;

[39.]41. Pulmonary rehabilitation. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and post-operative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

A. Member has a reduction of exercise tolerance that restricts the ability to perform activities of daily living (ADL) or work;

B. Member has chronic pulmonary disease (including asthma, emphysema, chronic bronchitis, chronic airflow obstruction, cystic fibrosis, alpha-1 antitrypsin deficiency, pneumoconiosis, asbestosis, radiation pneumonitis, pulmonary fibrosis, pulmonary alveolar proteinosis, pulmonary hemosiderosis, fibrosing alveolitis), or other conditions that affect pulmonary function such as ankylosing spondylitis, scoliosis, myasthenia gravis, muscular dystrophy, Guillain-Barré syndrome, or other infective polyneuritis, sarcoidosis, paralysis of diaphragm, or bronchopulmonary dysplasia; and

C. Member has a moderate to moderately severe functional pulmonary disability, as evidenced by either of the following, and does not have any concomitant medical condition that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g., symptomatic

coronary artery disease, congestive heart failure, myocardial infarction within the last six (6) months, dysrhythmia, active joint disease, claudication, malignancy):

(I) A maximal pulmonary exercise stress test under optimal bronchodilator treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake (VO_2max) equal to or less than twenty milliliters per kilogram per minute (20 mL/kg/min), or about five (5) metabolic equivalents (METs); or

(II) Pulmonary function tests showing that either the Forced Expiratory Volume in One Second (FEV1), Forced Vital Capacity (FVC), FEV1/FVC, or Diffusing Capacity of the Lung for Carbon Monoxide (DLCO) is less than sixty percent (60%) of that predicted;

[40.]42. Skilled Nursing Facility. Skilled nursing facility services are covered up to one hundred twenty (120) days per calendar year;

[41.]43. Telehealth Services. Telehealth services are covered for the diagnosis, consultation, or treatment of a member on the same basis that the service would be covered when it is delivered in person;

[42.]44. Therapy. Physical, occupational, and speech therapy are covered when prescribed by a provider and subject to the provisions below:

A. Physical therapy.

(I) Physical therapy must meet the following criteria:

(a) The program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, congenital defect, or surgery;

(b) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(c) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

B. Occupational therapy must meet the following criteria:

(I) The program is designed to improve or compensate for lost or impaired physical functions, particularly those affecting activities of daily living, resulting from illness, injury, congenital defect, or surgery;

(II) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(III) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

C. Speech therapy.

(I) All of the following criteria must be met for coverage of speech therapy:

(a) The therapy requires one-to-one intervention and supervision of a speech-language pathologist;

(b) The therapy plan includes specific tests and measures that will be used to document significant progress every two (2) weeks;

(c) Meaningful improvement is expected;

(d) The therapy includes a transition from one-to-one supervision to a self- or caregiver- provided maintenance program upon discharge; and

(e) One (1) of the following:

I. Member has severe impairment of speech-language; and an evaluation has been completed by a certified speech-language pathologist that includes age-appropriate standardized tests to measure the extent of the impairment, performance deviation, and language and pragmatic skill assessment levels; or

II. Member has a significant voice disorder that is the result of anatomic abnormality, neurological condition, or injury (e.g., vocal nodules or polyps, vocal cord paresis or paralysis, post-operative vocal cord surgery);

[43.]45. Transplants. Stem cell, kidney, liver, heart, lung, pancreas, small bowel, or any combination are covered. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements.

A. Network includes travel and lodging allowance for the transplant recipient and an immediate family travel companion when

the transplant facility is more than fifty (50) miles from the recipient's residence. If the recipient is younger than age nineteen (19) years, travel and lodging is covered for both parents. The transplant recipient must be with the travel companion or parent(s) for the travel companion's or parent(s)' travel expense to be reimbursable. Combined travel and lodging expenses are limited to a ten thousand dollar (\$10,000) maximum per transplant.

(I) Lodging—maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to www.gsa.gov for per diem rates.

(II) Travel—IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).

(III) Meals—not covered.

B. Non-network. Charges above the maximum for services rendered at a non-network facility are the member's responsibility and do not apply to the member's deductible or out-of-pocket maximum. Travel, lodging, and meals are not covered;

[44.]46. Urgent care. Member encounter with a provider for urgent care is covered based on the service, procedure, or related treatment plan; and

[45.]47. Vision. One (1) routine exam and refraction is covered per calendar year.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed amendment covering this same material is published in this issue of the Missouri Register.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN

Division 10—Health Care Plan Chapter 2—State Membership

EMERGENCY RESCISSION

22 CSR 10-2.060 PPO 300 Plan, PPO 600 Plan, and Health Savings Account Plan Limitations. This rule established the policy of the board of trustees in regard to the PPO 300 Plan, PPO 600 Plan, and Health Savings Account (HSA) Plan limitations of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded because the PPO 300 and PPO 600 Plans will not be offered after December 31, 2018.

EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency rescission is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be filed as an emergency rescission to maintain the integrity of the current health care plan. This emergency rescission fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP

trust fund from more costly expenses. This emergency rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the **Missouri Register**. This emergency rescission complies with the protections extended by the **Missouri and United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rescission was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.

AUTHORITY: sections 103.059 and 103.080.3., RSMo 2016. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the **Code of State Regulations**. Emergency rescission filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed rescission covering this same material is published in this issue of the **Missouri Register**.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

EMERGENCY RULE

22 CSR 10-2.061 Plan Limitations

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 750 Plan, PPO 1250 Plan, and Health Savings Account (HSA) Plan limitations of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency rule is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule to maintain the integrity of the current health care plan. This emergency rule fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the **Missouri Register**. This emergency rule complies with the protections extended by the **Missouri and United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.

(1) Benefits shall not be payable for, or in connection with, any medical benefits, services, or supplies which do not come within the definition of covered charges. In addition, the items specified in this rule are not covered unless expressly stated otherwise and then only to the extent expressly provided herein or in 22 CSR 10-2.055 or 22 CSR 10-2.090.

(A) Abortion—unless the life of the mother is endangered if the fetus is carried to term or due to death of the fetus.

(B) Acts of war including—injury or illness caused, or contributed to, by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.

(C) Alternative therapies—that are outside conventional medicine including, but not limited to, acupuncture, acupressure, homeopathy, hypnosis, massage therapy, reflexology, and biofeedback.

(D) Assistive listening device.

(E) Assistant surgeon services—unless determined to meet the clinical eligibility for coverage under the plan.

(F) Athletic enhancement services and sports performance training.

(G) Autopsy.

(H) Birthing center.

(I) Blood donor expenses.

(J) Blood pressure cuffs/monitors.

(K) Care received without charge.

(L) Charges exceeding the vendor contracted rate or benefit limit.

(M) Charges resulting from the failure to appropriately cancel a scheduled appointment.

(N) Childbirth classes.

(O) Comfort and convenience items.

(P) Cosmetic procedures.

(Q) Custodial or domiciliary care—including services and supplies that assist members in the activities of daily living such as walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet; preparation of special diets; supervision of medication that is usually self-administered; or other services that can be performed by persons who are not providers.

(R) Dental care, including oral surgery.

(S) Devices or supplies bundled as part of a service are not separately covered.

(T) Dialysis received through a non-network provider.

(U) Educational or psychological testing unless part of a treatment program for covered services.

(V) Examinations requested by a third party.

(W) Exercise equipment.

(X) Experimental/investigational/unproven services, procedures, supplies, or drugs as determined by the claims administrator.

(Y) Eye services and associated expenses for orthoptics, eye exercises, radial keratotomy, LASIK, and other refractive eye surgery.

(Z) Genetic testing based on family history alone, except for breast cancer susceptibility gene (BRCA) testing.

(AA) Health and athletic club membership—including costs of enrollment.

(BB) Hearing aid replacement batteries.

(CC) Home births.

(DD) Infertility treatment beyond the covered services to diagnose the condition.

(EE) Infusions received through a non-network provider.

(FF) Level of care, greater than is needed for the treatment of the illness or injury.

(GG) Long-term care.

(HH) Maxillofacial surgery.

(II) Medical care and supplies to the extent that they are payable under—

1. A plan or program operated by a national government or one (1) of its agencies; or

2. Any state's cash sickness or similar law, including any group insurance policy approved under such law.

(JJ) Medical service performed by a family member—including a person who ordinarily resides in the subscriber's household or is

related to the member, such as a spouse, parent, child, sibling, or brother/sister-in-law.

(KK) Military service-connected injury or illness—including expenses relating to Veterans Affairs or a military hospital.

(LL) Never events—never events on a list compiled by the National Quality Forum of inexcusable outcomes in a health care setting.

(MM) Nocturnal enuresis alarm.

(NN) Drugs that the pharmacy benefit manager (PBM) has excluded from the formulary and will not cover as a non-formulary drug unless it is approved in advance by the PBM.

(OO) Non-medically necessary services.

(PP) Non-provider allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning.

(QQ) Non-reusable disposable supplies.

(RR) Online weight management programs.

(SS) Other charges as follows:

1. Charges that would not otherwise be incurred if the subscriber was not covered by the plan;

2. Charges for which the subscriber or his/her dependents are not legally obligated to pay including, but not limited to, any portion of any charges that are discounted;

3. Charges made in the subscriber's name but which are actually due to the injury or illness of a different person not covered by the plan; and

4. No coverage for miscellaneous service charges including, but not limited to, charges for telephone consultations, administrative fees such as filling out paperwork or copy charges, or late payments.

(TT) Over-the-counter medications with or without a prescription including, but not limited to, analgesics, antipyretics, non-sedating antihistamines, unless otherwise covered as a preventive service.

(UU) Physical and recreational fitness.

(VV) Private-duty nursing.

(WW) Routine foot care without the presence of systemic disease that affects lower extremities.

(XX) Services obtained at a government facility if care is provided without charge.

(YY) Sex therapy.

(ZZ) Surrogacy—pregnancy coverage is limited to plan member.

(AAA) Telehealth site origination fees or costs for the provision of telehealth services are not covered.

(BBB) Therapy. Physical, occupational, and speech therapy are not covered for the following:

1. Physical therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Physical therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

E. Work hardening programs;

F. Back school;

G. Vocational rehabilitation programs and any program with the primary goal of returning an individual to work;

H. Group physical therapy (because it is not one-on-one, individualized to the specific person's needs); or

I. Services for the purpose of enhancing athletic or sports performance;

2. Occupational therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Occupational therapy that duplicates services already

being provided as part of an authorized therapy program through another therapy discipline (e.g., physical therapy);

E. Work hardening programs;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Group occupational therapy (because it is not one-on-one, individualized to the specific person's needs); and

H. Driving safety/driver training; and

3. Speech or voice therapy—

A. Any computer-based learning program for speech or voice training purposes;

B. School speech programs;

C. Speech or voice therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

D. Group speech or voice therapy (because it is not one-on-one, individualized to the specific person's needs);

E. Maintenance programs of routine, repetitive drills/exercises that do not require the skills of a speech-language therapist and that can be reinforced by the individual or caregiver;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Therapy or treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

H. Therapy or treatment provided to improve or enhance job, school, or recreational performance; and

I. Long-term rehabilitative services when significant therapeutic improvement is not expected.

(CCC) Travel expenses.

(DDD) Vaccinations requested by third party.

(EEE) Workers' Compensation services or supplies for an illness or injury eligible for, or covered by, any federal, state, or local government Workers' Compensation Act, occupational disease law, or other similar legislation.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed rule covering this same material is published in this issue of the Missouri Register.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

EMERGENCY AMENDMENT

22 CSR 10-2.075 Review and Appeals Procedure. The Missouri Consolidated Health Care Plan is amending sections (1), (2), (3), (5), and (6).

PURPOSE: This amendment revises the names of the medical plans and clarifies general appeal provisions, the appeals process for Medicare members, and documentation requirements when submitting an appeal to add dependents.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the

first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the *Missouri Register*. This emergency amendment complies with the protections extended by the *Missouri* and *United States Constitutions* and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.

(1) Claims Submissions and Initial Benefit Determinations [for Medical and Non-Medicare Primary Pharmacy Services] PPO 750 Plan, PPO 1250 Plan, and Health Savings Account (HSA) Plan members.

(2) General Appeal Provisions [for Medical and Non-Medicare Primary Pharmacy Services].

(3) Appeal Process for Medical and Pharmacy Determinations for PPO 750 Plan, PPO 1250 Plan, and Health Savings Account (HSA) Plan members.

(5) In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines. **Decisions concerning eligibility for Medicare primary members may not be able to be granted pursuant to these guidelines if the decision is contrary to the rules controlling eligibility for Medicare Advantage plan as put forth by Centers for Medicare and Medicaid. Valid proof of eligibility must be included with the appeal if the enrollment request includes addition of dependent(s).** Payment in full for all past and current premiums due for enrollment requests must be included with the appeal if it cannot be collected through payroll deduction:

(A) If a subscriber currently has coverage under the plan, MCHCP may approve the subscriber's request to enroll his/her newborn or the newborn of an enrolled dependent retroactively to the date of birth if the appeal is received within three (3) months of the child's birth date. *Valid proof of eligibility must be included with the appeal*;

(6) Medicare [Primary Pharmacy] Appeals.

(B) Appeals rights and procedures for benefits covered by the Medicare Advantage Plan are provided as regulated by the Centers for Medicare and Medicaid Services. Members may contact the Medicare Advantage Plan for additional rights and procedures.

(C) Administrative Appeals as specified in subsection (3)(B) of this rule shall follow the procedures set forth in that subsection.

AUTHORITY: section 103.059, RSMo [2000] 2016. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed amendment covering this same material is published in this issue of the Missouri Register.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

EMERGENCY AMENDMENT

22 CSR 10-2.080 Miscellaneous Provisions. The Missouri Consolidated Health Care Plan is amending section (5).

PURPOSE: This amendment revises the names of the medical plans.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.

(5) The PPO [300] 750 Plan, PPO [600] 1250 Plan, and Health Savings Account Plan benefits including pharmacy are self-funded by the plan. MCHCP has subrogation rights under section 376.433, RSMo for any amounts expended for these benefits.

AUTHORITY: section 103.059, RSMo [2000] 2016. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed amendment covering this same material is published in this issue of the Missouri Register.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

EMERGENCY RULE

22 CSR 10-2.088 Medicare Advantage Plan for Non-Active Medicare Primary Members

PURPOSE: *This rule establishes the policy of the board of trustees in regard to the Medicare Advantage Plan for Non-active Medicare-primary members of the Missouri Consolidated Health Care Plan.*

EMERGENCY STATEMENT: *This emergency rule must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency rule is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule to maintain the integrity of the current health care plan. This emergency rule fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the **Missouri Register**. This emergency rule complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.*

(1) The medical benefit for non-Active Medicare primary members is provided through a fully-insured Group Medicare Advantage PPO Plan as regulated by the Centers for Medicare and Medicaid Services (CMS) herein after referred to as the Medicare Advantage Plan. For purposes of this rule non-Active Medicare primary members include: Medicare-eligible members who are eligible retirees, terminated vested subscribers, long-term disability subscribers, and their eligible dependents who have Medicare.

(A) Members must be enrolled in Medicare Parts A and B to be eligible for the Medicare Advantage Plan.

(B) Non-active subscribers that have Medicare and/or their dependents that have Medicare shall receive their medical benefit through the Medicare Advantage Plan.

(C) Subscribers enrolled in the Medicare Advantage Plan will choose another medical plan offered by MCHCP for their non-Medicare dependents.

(D) Beginning the first day of the month in which a non-active Medicare primary member turns sixty-five (65) years old, they shall be transferred to the Medicare Advantage Plan.

(E) A member who opts out of the Medicare Advantage Plan will lose MCHCP eligibility and will not be allowed to enroll in a medical plan at a later date unless otherwise provided for in these rules.

(2) The Medicare Advantage Plan design is defined by the vendor, including deductible, out-of-pocket maximum, and benefits covered. Benefits shall be substantially similar to the benefits offered to non-Medicare members.

(3) The Medicare Advantage Plan eligibility, enrollment, and termination requirements are determined by the plan administrator and are defined in 22 CSR 10-2.020, and in conjunction with the rules set forth by CMS.

(4) Appeals.

(A) Appeals concerning claims and benefits are managed by the vendor in accordance with CMS rules.

(B) Administrative appeals concerning eligibility and termination are managed by MCHCP in accordance with 22 CSR 10-2.075.

AUTHORITY: *section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed rule covering this same material is published in this issue of the **Missouri Register**.*

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

EMERGENCY AMENDMENT

22 CSR 10-2.089 Pharmacy Employer Group Waiver Plan for Medicare Primary Members. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: *This amendment clarifies eligibility for the Pharmacy Employer Group Waiver Plan, the Part B drug benefit, and preventive drugs; updates the Medicare Part D coverage stage and the copayment amounts; and removes language regarding the Medicare Prescription Drug Only Plan.*

EMERGENCY STATEMENT: *This emergency amendment must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.*

(1) The pharmacy benefit for Medicare primary **non-active** members is provided through a Pharmacy Employer Group Waiver Plan (EGWP) as regulated by the Centers for Medicare and Medicaid Services herein after referred to as the Medicare Prescription Drug Plan.

(A) *[The following Medicare primary members] Non-active subscribers that have Medicare primary coverage and their*

dependents that have Medicare primary coverage enrolled in *[the PPO 300, PPO 600, or]* the Medicare *[Prescription Drug Only]* **Advantage** Plan shall receive their pharmacy benefit through the Medicare Prescription Drug Plan[:].

[1. Active employee members that have Medicare primary coverage and their dependents that have Medicare primary coverage; and

2. Retiree members that have Medicare primary coverage and their dependents that have Medicare primary coverage.]

(B) The non-Medicare *[primary]* dependents of Medicare primary *[members]* **non-active subscribers** will not be in the Medicare Prescription Drug Plan but will have pharmacy benefit coverage as defined by 22 CSR 10-2.090.

(F) The Medicare Prescription Drug Plan is comprised of a Medicare Part D prescription drug plan contracted by MCHCP and some non-Part D medications that are not normally covered by a Medicare Part D prescription drug plan. The requirements for the Medicare Part D prescription drug plan are as follows:

1. The Centers for Medicare and Medicaid Services regulates the Medicare Part D prescription drug program. The Medicare Prescription Drug Plan abides by those regulations;

2. Initial Coverage Stage. Until a member's total yearly Part D prescription drug costs reach *[three thousand seven hundred fifty dollars (\$3,750)]* **three thousand eight hundred twenty dollars (\$3,820)**, the member will pay the following copayments:

A. Preferred Formulary Generic Drugs: thirty-one- (31-) day supply has *[an eight dollar (\$8)]* **a ten dollar (\$10)** copayment; sixty- (60-) day supply has a *[sixteen dollar (\$16)]* **twenty dollar (\$20)** copayment; ninety- (90-) day supply at retail has a *[twenty-four dollar (\$24)]* **thirty dollar (\$30)** copayment; and a ninety- (90-) day supply through home delivery has a *[twenty dollar (\$20)]* **twenty-five dollar (\$25)** copayment;

B. Preferred Formulary Brand Drugs: thirty-one- (31-) day supply has a *[thirty-five dollar (\$35)]* **forty dollar (\$40)** copayment; sixty- (60-) day supply has a *[seventy dollar (\$70)]* **an eighty (\$80) dollar** copayment; ninety- (90-) day supply at retail has a *[one hundred five dollar (\$105)]* **one hundred twenty (\$120) dollar** copayment; and a ninety- (90-) day supply through home delivery has *[an eighty-seven dollar and fifty cent (\$87.50)]* **a one hundred (\$100) dollar** copayment; and

C. Non-preferred Formulary Drugs and approved excluded drugs: thirty-one- (31-) day supply has a one hundred dollar (\$100) copayment; sixty- (60-) day supply has a two hundred dollar (\$200) copayment; ninety- (90-) day supply at retail has a three hundred dollar (\$300) copayment; and a ninety- (90-) day supply through home delivery has a two hundred fifty dollar (\$250) copayment;

3. Coverage Gap Stage. After a member's total yearly Part D prescription drug costs exceed *[three thousand seven hundred fifty dollars (\$3,750)]* **three thousand eight hundred twenty dollars (\$3,820)** and remain below *[five thousand dollars (\$5,000)]* **five thousand one hundred dollars (\$5,100)**, the member will continue to pay the same cost-sharing amount as in the Initial Coverage stage until the yearly out-of-pocket Part D prescription drug costs reach *[five thousand dollars (\$5,000)]* **five thousand one hundred dollars (\$5,100)**;

4. Catastrophic Coverage Stage. After a member's total yearly out-of-pocket Part D prescription drug costs reach *[five thousand dollars (\$5,000)]* **five thousand one hundred dollars (\$5,100)**, the member will pay the greater of—

A. Five percent (5%) coinsurance or a *[three dollar and thirty-five cent (\$3.35)]* **three dollar and forty cent (\$3.40)** copayment for covered generic drugs (including brand drugs treated as generics), with a maximum not to exceed the standard copayment during the Initial Coverage stage; or

B. Five percent (5%) coinsurance or an *[eight dollar and thirty-five cent (\$8.35)]* **eight dollar and fifty cent (\$8.50)** copayment for all other covered drugs, with a maximum not to exceed the standard copayment during the Initial Coverage stage; **and**

5. Amounts paid by the member or the plan for non-Part D prescription drugs will not count toward total Part D prescription drug costs or total Part D prescription drug out-of-pocket costs[: and].

[6. Medicare Prescription Drug Only Plan. Medicare retirees have the option of choosing the Medicare Prescription Drug Plan for coverage for prescription drugs only, without MCHCP medical coverage.]

(H) Medicare Part B Prescription Drugs **are excluded from the Medicare Prescription Drug Plan.** *[For covered Medicare Part B prescriptions, Medicare and MCHCP will coordinate to provide up to one hundred percent (100%) coverage for the drugs. To receive Medicare Part B prescriptions without a copayment or coinsurance, the subscriber must submit prescriptions and refills to a Medicare Part B contracted retail pharmacy which is in the pharmacy benefit manager (PBM) network. Medicare Part B prescriptions include, but are not limited to, the following:]*

[1. Diabetes testing and maintenance supplies;

2. Respiratory agents;

3. Immunosuppressants; and

4. Oral anti-cancer medications.]

(I) Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S Preventive Services Task Force (categories A and B) are covered at one hundred percent (100%) when filled at a network pharmacy. The following are also covered at one hundred percent (100%) when filled at a network pharmacy:

[1. Prescribed Vitamin D for all ages:

A. The dosage range for preventive Vitamin D at or below 1000 IU of Vitamin D₂ or D₃ per dose;

2. Zoster (shingles) vaccine and administration for members age fifty (50) years and older;]

[3.]1. [Influenza v]Vaccines and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

[4.]2. Preferred formulary brand contraception and non-preferred contraception when the provider determines a generic is not medically appropriate or a generic version is not available.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 30, 2013, effective Jan. 1, 2014, expired June 29, 2014. Original rule filed Oct. 30, 2013, effective June 30, 2014. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed amendment covering this same material is published in this issue of the Missouri Register.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.090 Pharmacy Benefit Summary. The Missouri Consolidated Health Care Plan is amending the purpose and section (1).

PURPOSE: *This amendment revises the names of the medical plans, copayments, preventive drugs, and out-of-pocket maximum.*

PURPOSE: *This rule establishes the policy of the board of trustees in regard to the benefit provisions, covered charges, limitations, and exclusions of the pharmacy benefit for the [PPO 300, PPO 600] PPO 750 Plan, PPO 1250 Plan, and Health Savings Account Plan of the Missouri Consolidated Health Care Plan.*

EMERGENCY STATEMENT: *This emergency amendment must be in*

place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri and United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.

(1) The pharmacy benefit provides coverage for prescription drugs. Vitamin and nutrient coverage is limited to prenatal agents, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents as prescribed by a provider to non-Medicare primary members.

(A) PPO [300] 750 Plan and PPO [600] 1250 Plan.

1. Network:

A. Preferred formulary generic drug copayment: *[Eight dollars (\$8)] Ten Dollars (\$10)* for up to a thirty-one- (31-) day supply; *[sixteen dollars (\$16)] twenty dollars (\$20)* for up to a sixty- (60-) day supply; and *[twenty-four dollars (\$24)] thirty dollars (\$30)* for up to a ninety- (90-) day supply for a generic drug on the formulary;

B. Preferred formulary brand drug copayment: *[Thirty-five dollars (\$35)] Forty dollars (\$40)* for up to a thirty-one- (31-) day supply; *[seventy dollars (\$70)] eighty dollars (\$80)* for up to a sixty- (60-) day supply; and *[one hundred and five dollars (\$105)] one hundred twenty dollars (\$120)* for up to a ninety- (90-) day supply for a brand drug on the formulary;

C. Non-preferred formulary drug and approved excluded drug copayment: One hundred dollars (\$100) for up to a thirty-one- (31-) day supply; two hundred dollars (\$200) for up to a sixty- (60-) day supply; and three hundred dollars (\$300) for up to a ninety- (90-) day supply for a drug not on the formulary;

D. Specialty drug copayment: Seventy-five dollars (\$75) for up to a thirty-one- (31-) day supply for a specialty drug on the formulary;

[D./E. Diabetic drug (as designated as such by the PBM) copayment: fifty percent (50%) of the applicable network copayment;

[E./F. Home delivery programs.

(I) Maintenance prescriptions may be filled through the pharmacy benefit manager's (PBM's) home delivery program. A member must choose how maintenance prescriptions will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

(a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2)

orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision and the amount charged will not apply to the out-of-pocket maximum.

(b) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM.

(II) Specialty drugs are covered only through the specialty home delivery network for up to a thirty-one- (31-) day supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. All specialty prescriptions must be filled through the PBM's specialty pharmacy, unless the prescription is identified by the PBM as emergent. The first fill of a specialty prescription identified to be emergent, may be filled through a retail pharmacy.

(a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply and charged a prorated copayment. If the member is able to continue with the medication, the remaining supply will be shipped and the member will be charged the remaining portion of the copayment. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment.

(III) Prescriptions filled through home delivery programs have the following copayments:

(a) Preferred formulary generic drug copayments: *[Eight dollars (\$8)] Ten dollars (\$10)* for up to a thirty-one- (31-) day supply; *[sixteen dollars (\$16)] twenty dollars (\$20)* for up to a sixty- (60-) day supply; and *[twenty dollars (\$20)] twenty-five dollars (\$25)* for up to a ninety- (90-) day supply for a generic drug on the formulary;

(b) Preferred formulary brand drug copayments: *[Thirty-five dollars (\$35)] Forty dollars (\$40)* for up to a thirty-one- (31-) day supply; *[seventy dollars (\$70)] eighty dollars (\$80)* for up to a sixty- (60-) day supply; and *[eighty-seven dollars and fifty cents (\$87.50)] one hundred dollars (\$100)* for up to a ninety- (90-) day supply for a brand drug on the formulary;

(c) Non-preferred formulary drug and approved excluded drug copayments: One hundred dollars (\$100) for up to a thirty-one- (31-) day supply; two hundred dollars (\$200) for up to a sixty- (60-) day supply; and two hundred fifty dollars (\$250) for up to a ninety- (90-) day supply for a drug not on the formulary;

(d) Specialty drug copayment: Seventy-five dollars (\$75) for up to a thirty-one- (31-) day supply; one hundred fifty (\$150) for up to sixty (60-) day supply; and two hundred twenty-five (\$225) for up to ninety- (90-) day supply for a specialty drug on the formulary;

[F./G. Diabetic drug (as designated as such by the PBM) copayment: fifty percent (50%) of the applicable network copayment;

[G./H. Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount;

[H./I. The copayment for a compound drug is based on the primary drug in the compound. The primary drug in a compound is the most expensive prescription drug in the mix. If any ingredient in the compound is excluded by the plan, the compound will be denied;

[I./J. If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug;

[J./K. If the physician allows for generic substitution and the member chooses a brand-name drug, the member is responsible for the generic copayment and the cost difference between the brand-name and generic drug which shall not apply to the out-of-pocket maximum;

L. Preferred select brand drugs, as determined by the PBM: Ten dollars (\$10) for up to a thirty-one- (31-) day supply; twenty dollars (\$20) for up to a sixty- (60-) day supply; and twenty-five dollars (\$25) for up to a ninety- (90-) day supply; and

[K./M.] Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy. The following are also covered at one hundred percent (100%) when filled at a network pharmacy:

[(I)] Prescribed Vitamin D for all ages;

(a) The dosage range for preventive Vitamin D at or below 1000 IU of Vitamin D₂ or D₃ per dose;

[(II)] Zoster (shingles) vaccine and administration for members age fifty (50) years and older;

[(III)](I) [Influenza v/Vaccine (and administration as)] recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

[(IV)](II) Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer;

[(V)](III) Prescribed preferred diabetic test strips and lancets; and

[(VI)](IV) One (1) preferred glucometer.

2. Non-network: If a member chooses to use a non-network pharmacy for non-specialty prescriptions, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable network copayment.

3. Out-of-pocket maximum.

A. Network and non-network out-of-pocket maximums are separate.

B. The family out-of-pocket maximum is an aggregate of applicable charges received by all covered family members of the plan. Any combination of covered family member applicable charges may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.

C. **Network** **[(I)]individual—[five thousand one hundred dollars (\$5,100)] four thousand one hundred fifty dollars (\$4,150).**

D. **Network** **[(F)]family—[ten thousand two hundred dollars (\$10,200)] eight thousand three hundred dollars (\$8,300).**

E. **Non-network—no maximum.**

(B) Health Savings Account (HSA) Plan Prescription Drug Coverage. Medical and pharmacy expenses are combined to apply toward the appropriate network or non-network deductible and out-of-pocket maximum specified in 22 CSR 10-2.053.

1. Network:

A. Preferred formulary generic drug: Ten percent (10%) coinsurance after deductible has been met for a generic drug on the formulary;

B. Preferred formulary brand drug: Twenty percent (20%) coinsurance after deductible has been met for a brand drug on the formulary;

C. Non-preferred formulary drug and approved excluded drug: Forty percent (40%) coinsurance after deductible has been met;

D. Diabetic drug (as designated as such by the PBM) coinsurance: fifty percent (50%) of the applicable network coinsurance after deductible has been met;

E. Home delivery programs.

(I) Maintenance prescriptions may be filled through the PBM's home delivery program. A member must choose how maintenance prescriptions will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

(a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescrip-

tion at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision.

(b) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM.

(II) Specialty drugs are covered only through the specialty home delivery network for up to a thirty-one- (31-) day supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. All specialty prescriptions must be filled through the PBM's specialty pharmacy, unless the prescription is identified by the PBM as emergent. The first fill of a specialty prescription identified to be emergent, may be filled through a retail pharmacy.

(a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply. If the member is able to continue with the medication, the remaining supply will be shipped. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment;

F. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy. The following are also covered at one hundred percent (100%) when filled at a network pharmacy:

[(I)] Prescribed Vitamin D for all ages;

(a) The dosage range for preventive Vitamin D is at or below 1000 IU of Vitamin D₂ or D₃ per dose;

[(II)] Zoster (shingles) vaccine and administration for members age fifty (50) years and older;

[(III)](I) [Influenza v/Vaccines and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

[(IV)](II) Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer;

G. The following are covered at one hundred percent (100%) after deductible is met and when filled at a network pharmacy:

(I) Prescribed preferred diabetic test strips and lancets; and

(II) One (1) preferred glucometer;

H. If any ingredient in a compound drug is excluded by the plan, the compound will be denied.

2. Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable deductible or coinsurance.

A. Preferred formulary generic drug: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a generic drug on the formulary.

B. Preferred formulary brand drug: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a brand drug on the formulary.

C. Non-preferred formulary drug and approved excluded drug: Fifty percent (50%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a drug not on the formulary.

D. Diabetic drug (as designated as such by the PBM) coinsurance: fifty percent (50%) of the applicable non-network coinsurance after deductible has been met.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2005, effective Jan. 1, 2006, expired June 29, 2006. Original rule filed Dec. 22, 2005, effective June 30, 2006. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

EMERGENCY AMENDMENT

22 CSR 10-2.110 General Foster Parent Membership Provisions.
The Missouri Consolidated Health Care Plan is amending sections (2), (3), and (5).

PURPOSE: This amendment revises foster parent eligibility requirements, enrollment procedures, enrollment of a newborn child proof of eligibility procedures, and disabled dependent documentation timeframes.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.

(2) Eligibility Requirements.

(B) Dependent Coverage. Eligible dependents include:

1. Spouse. If both spouses are eligible foster parents, each spouse must enroll separately;

2. Children.

A. Children may be covered through the end of the month in which they turn twenty-six (26) years old if they meet one (1) of the following criteria:

(I) Natural child of subscriber or spouse;

(II) Legally-adopted child of subscriber or spouse;

(III) Child legally placed for adoption of subscriber or spouse;

(IV) Stepchild of subscriber. Such child will continue to be considered a dependent after the stepchild relationship ends due to the death of the child's natural parent and subscriber's spouse;

(V) Foster child of subscriber or spouse. Such child will continue to be considered a dependent after the foster child relationship ends by operation of law when the child ages out if the foster child relationship between the subscriber or spouse and the child was in effect the day before the child ages out;

(VI) Grandchild for whom the subscriber or spouse has legal guardianship or legal custody;

(VII) A child for whom the subscriber or spouse is the court-ordered legal guardian under a guardianship of a minor. Such child will continue to be considered a dependent after the guardianship ends by operation of law when the child becomes eighteen (18) years old if the guardianship of a minor relationship between the subscriber or spouse and the child was in effect the day before the child became eighteen (18) years old;

(VIII) *[Newborn]* Child of a dependent *[or]* as long as the parent is a dependent on the newborn's date of birth. The dependent and the child of the dependent must remain continuously covered on the plan for the child of the dependent to remain eligible;

(IX) *[c]* Child of a dependent when paternity by the dependent is established after birth *[so]* as long as the parent is a dependent on *[the newborn's day of birth or]* the date the child's paternity was established *[and continues to be covered as a dependent of the subscriber]* The dependent and the child of the dependent must remain continuously covered on the plan for the child of the dependent to remain eligible; or

[(X)] Child for whom the subscriber or spouse is required to provide coverage under a Qualified Medical Child Support Order (QMCSO).

B. A child who is twenty-six (26) years old or older and is permanently disabled in accordance with subsection (5)(C) may be covered only if such child was disabled the day before the child turned twenty-six (26) years old and has remained continuously disabled.

C. A child may only be covered by one (1) parent if his/her parents are married to each other and are both covered under an MCHCP medical plan.

D. A child may have dual coverage if the child's parents are divorced or have never married, and both have coverage under an MCHCP medical plan. MCHCP will only pay for a service once, regardless of whether the claim for the child's care is filed under multiple subscribers' coverage. If a child has coverage under two (2) subscribers, the child will have a separate deductible, copayment, and coinsurance under each subscriber. The claims administrator will process the claim and apply applicable cost-sharing using the coverage of the subscriber who files the claim first. The second claim for the same services will not be covered. If a provider files a claim simultaneously under both subscribers' coverage, the claim will be processed under the subscriber whose birthday is first in the calendar year. If both subscribers have the same birthday, the claim will be processed under the subscriber whose coverage has been in effect for the longest period of time; or

3. Changes in dependent status. If a dependent loses his/her eligibility, the subscriber must notify MCHCP within thirty-one (31) days of the loss of eligibility. Coverage will end on the last day of the month that the completed form is received by MCHCP or the last day of the month MCHCP otherwise receives credible evidence of loss of eligibility under the plan.

(3) Enrollment Procedures.

(C) An eligible foster parent may *[apply for]* elect or change coverage for himself/herself and/or for his/her spouse/child(ren) if one (1) of the following occurs:

1. Occurrence of a life event, which includes marriage, birth, adoption, and placement of child(ren). A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the eligible foster parent's responsibility to notify MCHCP of the life event;

A. If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

2. Employer-sponsored group coverage loss. An eligible foster parent *[and]* or his/her spouse/child(ren) may enroll within sixty (60) days *[if s/he involuntarily loses]* due to an involuntary loss

of employer-sponsored coverage under one (1) of the following circumstances:

- A. Employer-sponsored medical, dental, or vision plan terminates;
 - B. Eligibility for employer-sponsored coverage ends;
 - C. Employer contributions toward the premiums end; or
 - D. Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage ends; or
3. If an eligible foster parent or his/her spouse/child(ren) loses MO HealthNet or Medicaid status, s/he may enroll in an MCHCP plan within sixty (60) days of the date of loss; or
4. If an eligible foster parent or eligible foster parent's spouse receives a court order stating s/he is responsible for covering a child, the eligible foster parent may enroll the child in an MCHCP plan within sixty (60) days of the court order; or

5. Default Enrollment

/5./A. If an eligible foster parent is enrolled in the PPO 300 or PPO 600 Plan and does not complete enrollment during the open enrollment period, the foster parent and his/her dependents will be enrolled at the same level of coverage in the PPO ~~/600/~~ **1250** Plan provided through the vendor the foster parent is enrolled in, effective the first day of the next calendar year; or

/6./B. If an eligible foster parent is enrolled in the Health Savings Account (HSA) Plan and does not complete enrollment during the open enrollment period, the foster parent and his/her dependents will be enrolled at the same level of coverage in the HSA Plan provided through the vendor the foster parent is enrolled in, effective the first day of the next calendar year;

/7./C. If an eligible foster parent is enrolled in dental and/or vision coverage and does not complete open enrollment to cancel coverage or change the current level of coverage during the open enrollment period, the foster parent and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year; or

/8./6. If an eligible foster parent submits an Open Enrollment Worksheet or an Enroll/Change/Cancel form that is incomplete or contains obvious errors, MCHCP will notify the foster parent of such by mail, phone, or secure message. The foster parent must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date MCHCP notifies the foster parent, whichever is later.

(5) Proof of Eligibility. Proof of eligibility documentation is required for all dependents and subscribers, as necessary. Enrollment is not complete until proof of eligibility is received by MCHCP. A subscriber must include his/her MCHCPid or Social Security number on the documentation. If proof of eligibility is not received, MCHCP will send a letter requesting it from the subscriber. Except for open enrollment, documentation must be received within thirty-one (31) days of the date MCHCP processed the enrollment, or coverage will not take effect for those individuals whose proof of eligibility was not received. MCHCP reserves the right to request that such proof of eligibility be provided at any time upon request. If such proof is not received or is unacceptable as determined by MCHCP, coverage will terminate or never take effect. If enrolling during open enrollment, proof of eligibility must be received by November 20, or coverage will not take effect the following January 1 for those individuals whose proof of eligibility was not received. If invalid proof of eligibility is received, the subscriber is allowed an additional ten (10) days from the initial due date to submit valid proof of eligibility.

(A) When enrolling a newborn **child**, the *[member]* **subscriber** must notify MCHCP of the birth verbally or in writing within thirty-one (31) days of the birth date. MCHCP will then send an enrollment form and letter notifying the *[member]* **subscriber** of the steps to initiate coverage. The *[member]* **subscriber** is allowed an additional ten (10) days from the date of the plan notice to return the enrollment form. Coverage will not begin unless the enrollment form is received within thirty-one (31) days of the birth date or ten (10) days from the date of the notice, whichever is later. Newborn proof

of eligibility must be submitted within ninety (90) days of the birth date. If proof of eligibility is not received, coverage will terminate on day ninety-one (91) from the birth date.

(E) Disabled Dependent.

1. A newly eligible foster parent may enroll his/her permanently disabled child or an enrolled permanently disabled dependent turning age twenty-six (26) years, may continue coverage beyond age twenty-six (26) years, provided the following documentation is submitted to the plan prior to the **end of the month of the dependent's twenty-sixth birthday** for the enrolled permanently disabled dependent or within thirty-one (31) days of enrollment of a new foster parent and his/her permanently disabled child:

A. Evidence from the Social Security Administration (SSA) that the permanently disabled dependent or child was entitled to and receiving disability benefits prior to turning age twenty-six (26) years; and

B. A benefit verification letter dated within the last twelve (12) months from the SSA confirming the child is still considered disabled.

2. If a disabled dependent over the age of twenty-six (26) years is determined to be no longer disabled by the SSA, coverage will terminate the last day of the month in which the disability ends or never take effect for new enrollment requests.

3. Once the disabled child's coverage is cancelled or terminated, s/he will not be able to enroll at a later date.

AUTHORITY: sections 103.059 and 103.078, RSMo 2016. Emergency rule filed Aug. 28, 2012, effective Oct. 1, 2012, terminated Feb. 27, 2013. Original rule filed Aug. 28, 2012, effective Feb. 28, 2013. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed amendment covering this same material is published in this issue of the Missouri Register.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 2—State Membership

EMERGENCY AMENDMENT

22 CSR 10-2.140 Strive for Wellness[®] Health Center Provisions, Charges, and Services. The Missouri Consolidated Health Care Plan is amending sections (2) and (4).

PURPOSE: This amendment clarifies available services and preventive services; and revises the names of the medical plans.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to

members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the *Missouri Register*. This emergency amendment complies with the protections extended by the *Missouri* and *United States Constitutions* and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.

(2) Available Services. The health center provides access to treatment for uncomplicated minor illnesses and to preventive health care services including, but not limited to, the following:

(I) *[Immunizations]* **Vaccinations** including *[immunization for]* influenza **vaccine**;

(O) Ordinary and routine care of the nature of a visit to the *[doctor's]* **health care provider's** office; and

(4) Charges for the following services apply:

(A) Office visit—

1. For active employees enrolled in the MCHCP PPO *[300/750]* or PPO *[600/1250]* Plan, fifteen dollars (\$15) payable at the time of service;

2. For active employees enrolled in the Health Savings Account (HSA) Plan forty-five dollars (\$45) payable at the time of service; and

3. The office visit includes the evaluation and management of the patient and any associated laboratory services performed by the health center;

(B) Preventive *[care]* **services**—

1. For active employees enrolled in the MCHCP PPO *[300/750]* Plan, PPO *[600/1250]* Plan, or HSA Plan, preventive *[care is]* **services** are covered at one hundred percent (100%); and

2. Preventive *[care]* **services** shall have the same meaning as in 22 CSR 10-2.055; and

(C) Health center services are outside the MCHCP PPO *[300/750]* Plan, PPO *[600/1250]* Plan, and HSA Plan benefits and payments for health center services do not apply toward any associated deductible or out-of-pocket maximum.

AUTHORITY: section 103.059, RSMo [2000] 2016. Emergency rule filed Oct. 30, 2013, effective Jan. 1, 2014, expired June 29, 2014. Original rule filed Oct. 30, 2013, effective June 30, 2014. Amended: Filed Oct. 29, 2014, effective May 30, 2015. Amended: Filed Oct. 28, 2015, effective May 30, 2016. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed amendment covering this same material is published in this issue of the Missouri Register.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

EMERGENCY AMENDMENT

22 CSR 10-3.010 Definitions. The Missouri Consolidated Health Care Plan is amending sections (19), (28), (35), (46), (47), and (70) and renumbering as necessary.

PURPOSE: This amendment revises the definitions of diabetes education, essential benefits, Health Savings Account Plan, network, and non-network; and removes the definition of terminated vested subscriber because it is duplicative of section (73); and renumbers as

necessary.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the *Missouri Register*. This emergency amendment complies with the protections extended by the *Missouri* and *United States Constitutions* and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.

(19) Diabetes **self-management** education/**training**. A program prescribed by a provider and taught by a Certified Diabetes Educator to educate and support members with diabetes.

(28) Essential benefits. The plan covers essential benefits as required by the Patient Protection and Affordable Care Act. Essential benefits include:

(J) Pediatric services, including oral and vision care—routine vision exam, dental care/accidental injury, *[immunizations]* **vaccinations**, preventive services, and newborn screenings.

(35) *[Health Savings Account (HSA)]* **High deductible health [P/]plan**. A health plan with a higher deductible than a traditional health plan that, when combined with an **Health Savings Account (HSA)**, provides a tax-advantaged way to help save for future medical expenses.

(46) Network. The *[facilities,]* providers[, and suppliers] the health insurer or plan has contracted with to provide health care services to members.

(47) Non-network. The *[facilities,]* providers, *[and suppliers]* the health insurer, or plan does not contract with to provide health care services to members. Some providers may be a part of secondary provider networks recognized by the vendor for non-network benefits.

[(70) Terminated vested subscriber. A previous active employee eligible for a future retirement benefit through a public entity's retirement system.]

[(71)](70) Termination of coverage. The termination of medical, dental, or vision coverage initiated by the employer or required by

MCHCP eligibility policies.

[(72)](71) Usual, customary, and reasonable. The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service.

[(73)](72) Vendor. The current applicable third-party administrators of MCHCP benefits or other services.

[(74)](73) Vested subscriber. An active employee eligible for coverage under the plan and eligible for future benefits through a public entity's retirement system.

[(75)](74) Waiting/probationary periods. The length of time the employer requires an employee to be employed before he or she is eligible for health insurance coverage. Public entities may set different waiting/probationary periods for different employee classifications (full-time vs. part-time).

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed amendment covering this same material is published in this issue of the Missouri Register.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN

Division 10—Health Care Plan

Chapter 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.020 General Membership Provisions. The Missouri Consolidated Health Care Plan is amending sections (2), (3), (5), and (8).

PURPOSE: This amendment revises public entity eligibility requirements, enrollment procedures, disabled dependent documentation timeframes, and voluntary cancellation of enrollment requirements.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency

amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.

(2) Eligibility Requirements.

(G) Dependent Coverage. Eligible dependents include:

1. Spouse.

A. Active Employee Coverage of a Spouse.

(I) If both spouses have access to MCHCP benefits through two (2) different public entities, the employee and his/her spouse may elect to enroll in coverage separately through his/her respective employer or together through one (1) of the employers. The employee cannot have coverage through both public entities.

(II) If both spouses are employed by the same public entity with access to MCHCP benefits, the employee and spouse may elect coverage either as individuals or under the spouse (if allowed by the employer).

B. Retiree Coverage of a Spouse.

(I) A public entity retiree may enroll as a spouse under a public entity employee's coverage or elect coverage as a retiree;

2. Children.

A. Children may be covered through the end of the month in which they turn twenty-six (26) years old if they meet one (1) of the following criteria:

(I) Natural child of subscriber or spouse;

(II) Legally-adopted child of subscriber or spouse;

(III) Child legally placed for adoption of subscriber or spouse;

(IV) Stepchild of subscriber. Such child will continue to be considered a dependent after the stepchild relationship ends due to the death of the child's natural parent and subscriber's spouse;

(V) Foster child of subscriber or spouse. Such child will continue to be considered a dependent child after the foster child relationship ends by operation of law when the child ages out if the foster child relationship between the subscriber or spouse and the child was in effect the day before the child ages out;

(VI) Grandchild for whom the subscriber or spouse has legal guardianship or legal custody;

(VII) A child for whom the subscriber or spouse is the court-ordered legal guardian under a guardianship of a minor. Such child will continue to be considered a dependent child after the guardianship ends by operation of law when the child becomes eighteen (18) years old if the guardianship of a minor relationship between the subscriber or spouse and the child was in effect the day before the child became eighteen (18) years old;

(VIII) *[Newborn]* Child of a dependent *[or]* as long as the parent is a dependent on the child's date of birth. The dependent and his/her child must remain continuously covered on the plan from the dependent's child's date of birth for the child of the dependent to remain eligible;

(IX) *[c]* Child of a dependent when paternity by the dependent is established after birth *[so]* as long as the parent is a dependent on *[the newborn's day of birth or]* the date the child's paternity was established *[and continues to be covered as a dependent of the subscriber]* the dependent and his/her child must remain continuously covered on the plan from the dependent's child's date of birth for the child of the dependent to remain eligible;

[(IX)](X) Child for whom the subscriber or spouse is required to provide coverage under a Qualified Medical Child Support Order (QMCSO); or

[(X)](XI) A child under twenty-six (26) years, who is eligible for MCHCP coverage as a subscriber, may be covered as a dependent of a public entity employee.

B. A child who is twenty-six (26) years old or older and is

permanently disabled in accordance with subsection (5)(F), may be covered only if such child was disabled the day before the child turned twenty-six (26) years old and has remained continuously disabled.

C. A child may only be covered by one (1) parent if his/her parents are married to each other and are both covered under an MCHCP medical plan.

D. A child may have dual coverage if the child's parents are divorced or have never married, and both have coverage under an MCHCP medical plan. MCHCP will only pay for a service once, regardless of whether the claim for the child's care is filed under multiple subscribers' coverage. If a child has coverage under two (2) subscribers, the child will have a separate deductible, copayment, and coinsurance under each subscriber. The claims administrator will process the claim and apply applicable cost-sharing using the coverage of the subscriber who files the claim first. The second claim for the same services will not be covered. If a provider files a claim simultaneously under both subscribers' coverage, the claim will be processed under the subscriber whose birthday is first in the calendar year. If both subscribers have the same birthday, the claim will be processed under the subscriber whose coverage has been in effect for the longest period of time; or

3. Changes in dependent status. If a dependent loses his/her eligibility, the subscriber must notify MCHCP within thirty-one (31) days of the loss of eligibility. Coverage will end on the last day of the month that the completed form is received by MCHCP or the last day of the month MCHCP otherwise receives credible evidence of loss of eligibility under the plan.

(3) Enrollment Procedures.

(A) Active Employee Coverage.

1. The public entity must enroll or waive coverage for a new employee by submitting a form signed by the employee and the payroll representative within thirty-one (31) days of his/her eligibility date. A new employee's coverage begins on the first day of the month after the hire date and the applicable waiting period.

2. An active employee may elect, change, or cancel coverage for the next plan year during the annual open enrollment period.

3. An active employee may *[apply for] elect or change* coverage for himself/herself and/or for his/her spouse/child(ren) if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of child(ren). A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event;

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. An employee and his/her spouse/child(ren) may enroll within sixty (60) days *[if s/he involuntarily loses] due to an involuntary loss* of employer-sponsored coverage under one (1) of the following circumstances:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends; or

C. If an active employee or his/her spouse/child(ren) loses MO HealthNet or Medicaid status, s/he may enroll in an MCHCP plan within sixty (60) days of the date of loss; or

D. If an active employee or active employee's spouse receives a court order stating s/he is responsible for covering a child(ren), the active employee may enroll the child(ren) in an MCHCP plan within sixty (60) days of the court order; or

E. If an active employee submits an Open Enrollment Worksheet or an Enroll/Change/Cancel/Waive form that is incomplete or contains obvious errors, MCHCP will notify the public entity's Human Resource Department of such by mail, phone, or secure

message. The corrected form must be submitted to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

4. If an active employee is enrolled and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the plan offered by the public entity for the new year. If the public entity offers two (2) plan options, the employee and his/her dependents will be enrolled at the same level of coverage in the low cost plan offered by the public entity, effective the first day of the next calendar year.

(B) Retiree Coverage.

1. To enroll or continue coverage for him/herself and his/her dependents at retirement, the employee must submit one (1) of the following:

A. A completed enrollment form within thirty-one (31) days of retirement date. Coverage is effective on retirement date; or

B. A completed enrollment form within thirty-one (31) days of retirement date with proof of prior medical, dental, or vision coverage under a separate group or individual insurance policy for six (6) months immediately prior to his/her retirement if s/he chooses to enroll in an MCHCP plan at retirement and has had insurance coverage for six (6) months immediately prior to his/her retirement.

2. A retiree may later add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of child(ren). A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event;

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A retiree may enroll his/her spouse/child(ren) within sixty (60) days *[if the spouse/child(ren) involuntarily loses] due to an involuntary loss* of employer-sponsored coverage under one (1) of the following circumstances, and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

3. If coverage was not maintained while on disability, the employee and his/her dependents may enroll him/herself and his/her spouse/child(ren) within thirty-one (31) days of the date the employee is eligible for retirement benefits subject to the eligibility provisions herein.

4. A retiree may change from one (1) medical plan to another during open enrollment but cannot add coverage for a spouse/child(ren). If a retiree is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

5. If a retiree submits an Open Enrollment Worksheet or an Enroll/Change/Cancel/Waive form that is incomplete or contains obvious errors, MCHCP will notify the retiree of such by mail, phone, or secure message. The retiree must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

6. If a retiree is enrolled and does not complete enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled at the same level of coverage in the plan offered by the public entity for the new year. If the public entity offers two (2) plan options, the retiree and his/her dependents will be enrolled at the same level of coverage in the low cost plan offered by the public entity, effective the first day of the next calendar year.

(C) Terminated Vested Coverage.

1. A terminated vested subscriber may later add a spouse/child(ren) to his/her coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event;

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A terminated vested subscriber may enroll his/her spouse/child(ren) within sixty (60) days *[if the spouse/child(ren) involuntarily loses]* **due to an involuntary loss** of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

2. An enrolled terminated vested subscriber may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If an enrolled terminated vested subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

3. If a terminated vested subscriber submits an Open Enrollment Worksheet or an Enroll/Change/Cancel/Waive form that is incomplete or contains obvious errors, MCHCP will notify the terminated vested subscriber of such by mail, phone, or secure message. The terminated vested subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

4. If a terminated vested subscriber is enrolled and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled at the same level of coverage in the plan offered by the public entity for the new year. If the public entity offers two (2) plan options, the terminated vested subscriber and his/her dependents will be enrolled at the same level of coverage in the low cost plan offered by the public entity, effective the first day of the next calendar year.

(D) Long-Term Disability Coverage.

1. A long-term disability subscriber may add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of child(ren). A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event;

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A long-term disability subscriber may enroll his/her spouse/child(ren) within sixty (60) days *[if the spouse/child(ren) involuntarily loses]* **due to an involuntary loss** of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

2. An enrolled long-term disability subscriber may change from one (1) medical plan to another during open enrollment but cannot

add a spouse/child(ren). If an enrolled long-term disability subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

3. If a long-term disability subscriber submits an Open Enrollment Worksheet or an Enroll/Change/Cancel/Waive form that is incomplete or contains obvious errors, MCHCP will notify the long-term disability subscriber of such by mail, phone, or secure message. The long-term disability subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

4. If a long-term disability subscriber is enrolled and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled at the same level of coverage in the plan offered by the public entity for the new year. If the public entity offers two (2) plan options, the long-term disability subscriber and his/her dependents will be enrolled at the same level of coverage in the low cost plan offered by the public entity, effective the first day of the next calendar year.

(E) Survivor Coverage.

1. A survivor must submit a form and a copy of the death certificate within thirty-one (31) days of the first day of the month after the death of the employee.

A. If the survivor does not elect coverage within thirty-one (31) days of the first day of the month after the death of the employee, s/he cannot enroll at a later date.

B. If the survivor marries, has a child, adopts a child, or a child is placed with the survivor, the spouse/child(ren) must be added within thirty-one (31) days of birth, adoption, placement, or marriage.

C. If eligible spouse/child(ren) are not enrolled when first eligible, they cannot be enrolled at a later date.

2. A survivor may later add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event;

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A survivor may enroll his/her spouse/child(ren) within sixty (60) days *[if the spouse/child(ren) involuntarily loses]* **due to an involuntary loss** of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

3. A survivor may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If a survivor is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

4. If a survivor submits an Open Enrollment Worksheet or an Enroll/Change/Cancel/Waive form that is incomplete or contains obvious errors, MCHCP will notify the survivor of such by mail, phone, or secure message. The survivor must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

5. If a survivor is enrolled and does not complete enrollment during the open enrollment period, the survivor and his/her dependents will be enrolled at the same level of coverage in the plan offered

by the public entity for the new year. If the public entity offers two (2) plan options, the survivor and his/her dependents will be enrolled at the same level of coverage in the low cost plan offered by the public entity, effective the first day of the next calendar year.

(5) Proof of Eligibility.

(F) Disabled dependent.

1. A new employee may enroll his/her permanently disabled child or an enrolled permanently disabled dependent turning age twenty-six (26) years and may continue coverage beyond age twenty-six (26) years, provided the following documentation is submitted to the plan prior to the **end of the month of the** dependent's twenty-sixth birthday for the enrolled permanently disabled dependent or within thirty-one (31) days of enrollment of a new employee and his/her permanently disabled child:

A. Evidence from the Social Security Administration (SSA) that the permanently disabled dependent or child was entitled to and receiving disability benefits prior to turning age twenty-six (26) years; and

B. A benefit verification letter dated within the last twelve (12) months from the SSA confirming the child is still considered disabled.

2. If a disabled dependent or child over the age of twenty-six (26) years is determined to be no longer disabled by the SSA, coverage will terminate the last day of the month in which the disability ends or never take effect for new enrollment requests.

3. Once the disabled dependent's coverage is cancelled or terminated, s/he will not be able to enroll at a later date.

(8) Voluntary Cancellation of Coverage.

(D) A subscriber may only cancel dental and/or vision coverage during the year for him/herself or his/her dependents for one (1) of the following reasons:

1. Upon retirement;
2. When beginning a leave of absence;
3. No longer eligible for coverage; *[or]*
4. When new coverage is taken through other employment*[.]; or*
5. **When the member enrolls in Medicaid.**

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed amendment covering this same material is published in this issue of the Missouri Register.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership
EMERGENCY AMENDMENT**

22 CSR 10-3.045 Plan Utilization Review Policy. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment adds preauthorization requirements for chemotherapy for cancer diagnosis, dialysis, and specialty injectibles; revises preauthorization requirements for surgery (outpatient); alphabetizes the list of medical services, and renumbers as necessary.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the

Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program has the following components:

(A) Preauthorization of Services—The claims administrator must authorize some services in advance. Without preauthorization, any claim that requires preauthorization will be denied for payment. Members who have another primary carrier, including Medicare, are not subject to this provision except for those services that are not covered by the other primary carrier, but are otherwise subject to preauthorization under this rule. Preauthorization does not verify eligibility or payment. Preauthorizations found to have a material misrepresentation or intentional or negligent omission about the person's health condition or the cause of the condition may be rescinded.

1. The following medical services are subject to preauthorization:

- A. Ambulance services for non-emergent use, whether air or ground;
- B. Anesthesia and hospital charges for dental care for children younger than five (5) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization;
- C. Applied behavior analysis for autism at initial service;
- D. Auditory brainstem implant (ABI);
- E. Bariatric surgery;
- F. Cardiac rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;
- G. **Chelation therapy;**
- H. **Chemotherapy for cancer diagnosis;**
- I. **Chiropractic services after twenty-six (26) visits annually;**

[H./J.] Cochlear implant device;

[I.] Chelation therapy;

[J./K.] Dental care;

L. Dialysis;

[K./M.] Durable medical equipment (DME) over one thousand five hundred dollars (\$1,500) or DME rentals over five hundred dollars (\$500) per month;

[L./N.] Genetic testing or counseling;

[M./O.] Hearing Aids;

[N./P.] Home health care;

[O./Q.] Hospice care and palliative services;

[P./R.] Hospital inpatient services;

[Q./S.] Imaging (diagnostic non-emergent outpatient), including magnetic resonance imaging (MRI), magnetic resonance angiography

(MRA), positron emission tomography (PET), computerized tomography scan (CT), computerized tomography angiography (CTA), electron-beam computed tomography (EBCT), and nuclear cardiology;

/R./T. Maternity coverage for maternity hospital stays longer than forty-eight (48) hours for vaginal delivery or ninety-six (96) hours for cesarean delivery;

/S./U. Nutritional counseling after six (6) sessions annually;

/T./V. Orthognathic surgery;

/U./W. Orthotics over one thousand dollars (\$1,000);

/V./X. Physical, speech, and occupational therapy and rehabilitation services (outpatient) after sixty (60) combined visits per calendar year;

/W./Y. Procedures with procedure codes ending in "T" (temporary procedure codes used for data collection, experimental, investigational, or unproven procedures);

/X./Z. Prostheses over one thousand dollars (\$1,000);

/Y./AA. Pulmonary rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;

/Z./BB. Skilled nursing facility;

CC. Specialty injectables;

/AA./DD. Surgery (outpatient)—The following outpatient surgical procedures: cornea transplant, potential cosmetic surgery, sleep apnea surgery, implantable stimulators, stimulators for bone growth, spinal surgery (including, but not limited to, artificial disc replacement, fusions, nonpulsed radiofrequency denervation, vertebroplasty, kyphoplasty, spinal cord stimulator trials, spinal cord stimulator implantation, and any unlisted spinal procedure), **total hip arthroplasty, total knee arthroplasty**, and oral surgery (excisions of tumors and cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological exams); and

/BB./EE. Transplants, including requests related to covered travel and lodging.

2. The following pharmacy services included in the prescription drug plan for non-Medicare primary members are subject to preauthorization:

A. Second-step therapy medications that skip the first-step medication trial;

B. Specialty medications;

C. Medications that may be prescribed for several conditions, including some for which treatment is not medically necessary;

D. Medication refill requests that are before the time allowed for refill;

E. Medications that exceed drug quantity and day supply limitations; and

F. Medications with costs exceeding nine thousand nine hundred ninety-nine dollars and ninety-nine cents (\$9,999.99) at retail or the mail order pharmacy and one hundred forty-nine dollars and ninety-nine cents (\$149.99) for compound medications at retail or the mail order pharmacy.

3. Preauthorization timeframes.

A. A benefit determination for non-urgent preauthorization requests will be made within fifteen (15) calendar days of the receipt of the request. The fifteen (15) days may be extended by the claims administrator for up to fifteen (15) calendar days if an extension is needed as a result of matters beyond the claims administrator's control. The claims administrator will notify the member of any necessary extension prior to the expiration of the initial fifteen- (15-) calendar-day period. If a member fails to submit necessary information to make a benefit determination, the member will be given at least ninety (90) calendar days from receipt of the extension notice to respond with additional information.

B. A benefit determination for urgent preauthorization requests will be made as soon as possible based on the clinical situation, but in no case later than twenty-four (24) hours of the receipt of the request;

AUTHORITY: section 103.059, RSMo [2000] 2016. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For inter-

vening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed amendment covering this same material is published in this issue of the Missouri Register.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 3—Public Entity Membership

EMERGENCY RECISSION

22 CSR 10-3.053 PPO 1000 Plan Benefit Provisions and Covered Charges. This rule established the policy of the board of trustees in regard to the PPO 1000 Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded because the PPO 1000 Plan will not be offered after December 31, 2018.

EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency rescission is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be filed as an emergency rescission to maintain the integrity of the current health care plan. This emergency rescission fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one method of protecting the MCHCP trust fund from more costly expenses. This emergency rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the Missouri Register. This emergency rescission complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rescission was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the Code of State Regulations. Emergency rescission filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed rescission covering this same material is published in this issue of the Missouri Register.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.055 Health Savings Account Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (1), (3), (6), (8), (10), and (12).

PURPOSE: This amendment revises the HSA Plan deductible, out-of-pocket maximum and clarifies influenza vaccinations, diabetes self-management education/training, family deductible, access to payment information, and maximum plan payments.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.

(1) Deductible—per calendar year for network: per individual, one thousand six hundred fifty dollars (\$1,650); family, three thousand three hundred dollars (\$3,300) and for non-network: per individual, **[four thousand dollars (\$4,000)] three thousand three hundred dollars (\$3,300)**; family, **[eight thousand dollars (\$8,000)] six thousand six hundred dollars (\$6,600)**.

(3) Out-of-pocket maximum.

(A) The family out-of-pocket maximum applies when two (2) or more family members are covered. The family out-of-pocket maximum must be met before the plan begins to pay one hundred percent (100%) of all covered charges for any covered family member. Out-of-pocket maximums are per calendar year, as follows:

1. Network out-of-pocket maximum for individual—**[three thousand three hundred dollars (\$3,300)] four thousand nine hundred fifty dollars (\$4,950)**;

2. Network out-of-pocket maximum for family—**[six thousand six hundred dollars (\$6,600)] nine thousand nine hundred dollars (\$9,900)**. Any individual family member need only incur a maximum of seven thousand nine hundred dollars (\$7,900) before the plan begins paying one hundred percent (100%) of covered charges for that individual;

3. Non-network out-of-pocket maximum for individual—**[five thousand dollars (\$5,000)] nine thousand nine hundred dollars (\$9,900)**; and

4. Non-network out-of-pocket maximum for family—**[ten thousand dollars (\$10,000)] nineteen thousand eight hundred**

dollars (\$19,800).

(6) Influenza *[immunizations]* **vaccinations** provided by a non-network provider will be reimbursed up to twenty-five dollars (\$25) once the member submits a receipt and a reimbursement form to the claims administrator.

(8) Four (4) diabetes **self-management** education/training visits with a certified diabetes educator when ordered by a provider and received through a network provider are covered at one hundred percent (100%) after deductible is met.

(10) Each subscriber will have access to payment information of the family unit **only when authorization is granted by the adult covered dependent(s)**.

(12) *[Usual, customary, and reasonable fee allowed]* **Maximum plan payment**—Non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed at *[the eightieth percentile of usual, customary, and reasonable fees as determined by the vendor]* **one hundred ten percent (110%) of Medicare reimbursement**. Members may be held liable for the amount of the fee above the allowed amount.

AUTHORITY: sections 103.059 and 103.080.3., RSMo 2016. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 3—Public Entity Membership

EMERGENCY RESCISSION

22 CSR 10-3.056 PPO 600 Plan Benefit Provisions and Covered Charges. This rule established the policy of the board of trustees in regard to the PPO 600 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded because the PPO 600 Plan will not be offered after December 31, 2018.

EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency rescission is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be filed as an emergency rescission to maintain the integrity of the current health care plan. This emergency rescission fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one method

of protecting the MCHCP trust fund from more costly expenses. This emergency rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the **Missouri Register**. This emergency rescission complies with the protections extended by the **Missouri and United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rescission was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. For intervening history, please consult the **Code of State Regulations**. Emergency rescission filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed rescission covering this same material is published in this issue of the **Missouri Register**.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

EMERGENCY AMENDMENT

22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (1) and (3).

PURPOSE: This amendment revises the names of the medical plans and clarifies the following benefits: dental care, diabetes education, dialysis, genetic counseling, infusions, injections, nutrition counseling, and preventive services; alphabetizes the list of medical benefits; and rennumbers as necessary.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri and United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 31, 2018, becomes effective January 1, 2019, and expires

June 29, 2019.

(1) Benefit Provisions Applicable to the PPO [600] 750 Plan, PPO [1000] 1250 Plan, and Health Savings Account (HSA) Plan. Subject to the plan provisions, limitations, and enrollment of the employee, the benefits are payable for covered charges incurred by a member while covered under the plans, provided the deductible requirement, if any, is met.

(3) Covered Charges Applicable to the PPO [600] 750 Plan, PPO [1000] 1250 Plan, and HSA Plan.

(E) Plan benefits for the PPO [600] 750 Plan, PPO [1000] 1250 Plan, and HSA Plan are as follows:

1. Allergy Testing and Immunotherapy. Allergy testing and allergy immunotherapy are considered medically necessary for members with clinically significant allergic symptoms. The following tests and treatments are covered:

A. Epicutaneous (scratch, prick, or puncture) when Immunoglobulin E- (IgE-) mediated reactions occur to any of the following:

- (I) Foods;
- (II) Hymenoptera venom (stinging insects);
- (III) Inhalants; or
- (IV) Specific drugs (penicillins and macromolecular

agents);

B. Intradermal (Intracutaneous) when IgE-mediated reactions occur to any of the following:

- (I) Foods;
- (II) Hymenoptera venom (stinging insects);
- (III) Inhalants; or
- (IV) Specific drugs (penicillins and macromolecular

agents);

C. Skin or Serial Endpoint Titration (SET), also known as intradermal dilutional testing (IDT), for determining the starting dose for immunotherapy for members highly allergic to any of the following:

- (I) Hymenoptera venom (stinging insects); or
- (II) Inhalants;

D. Skin Patch Testing: for diagnosing contact allergic dermatitis;

E. Photo Patch Testing: for diagnosing photo-allergy (such as photo-allergic contact dermatitis);

F. Photo Tests: for evaluating photo-sensitivity disorders;

G. Bronchial Challenge Test: for testing with methacholine, histamine, or antigens in defining asthma or airway hyperactivity when either of the following conditions is met:

- (I) Bronchial challenge test is being used to identify new allergens for which skin or blood testing has not been validated; or
- (II) Skin testing is unreliable;

H. Exercise Challenge Testing for exercise-induced bronchospasm;

I. Ingestion (Oral) Challenge Test for any of the following:

- (I) Food or other substances; or
- (II) Drugs when all of the following are met:
 - (a) History of allergy to a particular drug;
 - (b) There is no effective alternative drug; and
 - (c) Treatment with that drug class is essential;

J. In Vitro IgE Antibody Tests (RAST, MAST, FAST, ELISA, ImmunoCAP) are covered for any of the following:

- (I) Allergic broncho-pulmonary aspergillosis (ABPA) and certain parasitic diseases;
- (II) Food allergy;
- (III) Hymenoptera venom allergy (stinging insects);
- (IV) Inhalant allergy; or
- (V) Specific drugs;

K. Total Serum IgE for diagnostic evaluation in members with known or suspected ABPA and/or hyper IgE syndrome;

L. Lymphocyte transformation tests such as lymphocyte mitogen response test, PHE stimulation test, or lymphocyte antigen

response assay are covered for evaluation of persons with any of the following suspected conditions:

(I) Sensitivity to beryllium;
(II) Congenital or acquired immunodeficiency diseases affecting cell-mediated immunity, such as severe combined immunodeficiency, common variable immunodeficiency, X-linked immunodeficiency with hyper IgM, Nijmegen breakage syndrome, reticular dysgenesis, DiGeorge syndrome, Nezelof syndrome, Wiscott-Aldrich syndrome, ataxia telangiectasia, and chronic mucocutaneous candidiasis;

(III) Thymoma; and

(IV) To predict allograft compatibility in the transplant setting;

M. Allergy retesting: routine allergy retesting is not considered medically necessary;

N. Allergy immunotherapy is covered for the treatment of any of the following IgE-mediated allergies:

(I) Allergic (extrinsic) asthma;

(II) Dust mite atopic dermatitis;

(III) Hymenoptera (bees, hornets, wasps, fire ants) sensitive individuals;

(IV) Mold-induced allergic rhinitis;

(V) Perennial rhinitis;

(VI) Seasonal allergic rhinitis or conjunctivitis when one

(1) of the following conditions are met:

(a) Member has symptoms of allergic rhinitis or asthma after natural exposure to the allergen;

(b) Member has a life-threatening allergy to insect stings; or

(c) Member has skin test or serologic evidence of IgE-mediated antibody to a potent extract of the allergen; and

(VII) Avoidance or pharmacologic therapy cannot control allergic symptoms or member has unacceptable side effects with pharmacologic therapy;

O. Other treatments: the following other treatments are covered:

(I) Rapid, rush, cluster, or acute desensitization for members with any of the following conditions:

(a) IgE antibodies to a particular drug that cannot be treated effectively with alternative medications;

(b) Insect sting (e.g., wasps, hornets, bees, fire ants) hypersensitivity (hymenoptera); or

(c) Members with moderate to severe allergic rhinitis who need treatment during or immediately before the season of the affecting allergy;

(II) Rapid desensitization is considered experimental and investigational for other indications;

P. Epinephrine kits, to prevent anaphylactic shock for members who have had life-threatening reactions to insect stings, foods, drugs, or other allergens; have severe asthma or if needed during immunotherapy;

2. Ambulance service. The following ambulance transport services are covered:

A. By ground to the nearest appropriate facility when other means of transportation would be contraindicated;

B. By air to the nearest appropriate facility when the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate or contraindicated;

3. Applied Behavior Analysis (ABA) for Autism;

4. Bariatric surgery. Bariatric surgery is covered when all of the following requirements have been met:

A. The surgery is performed at a facility accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) for the billed procedure;

B. The following open or laparoscopic bariatric surgery procedures are covered:

(I) Roux-en-Y gastric bypass;

(II) Sleeve gastrectomy;

(III) Biliopancreatic diversion with duodenal switch for individuals with a body mass index (BMI) greater than fifty (50);

(IV) Adjustable silicone gastric banding and adjustments of a silicone gastric banding to control the rate of weight loss and/or treat symptoms secondary to gastric restriction following an adjustable silicone gastric banding procedure;

(V) Surgical reversal of bariatric surgery when complications of the original surgery (e.g., stricture, pouch dilatation, erosion, or band slippage) cause abdominal pain, inability to eat or drink, or cause vomiting of prescribed meals;

(VI) Revision of a previous bariatric surgical procedure or conversion to another procedure due to inadequate weight loss when one (1) of the following specific criteria has been met:

(a) There is evidence of full compliance with the previously prescribed post-operative dietary and exercise program; or

(b) There is documented clinical testing demonstrating technical failure of the original bariatric surgical procedure which caused the individual to fail achieving adequate weight loss of at least fifty percent (50%) of excess body weight or failure to achieve body weight to within thirty percent (30%) of ideal body weight at least two (2) years following the original surgery;

C. All of the following criteria have been met:

(I) The member is eighteen (18) years or older or has reached full skeletal growth, and has evidence of one (1) of the following:

(a) BMI greater than forty (40); or

(b) BMI between thirty-five (35) and thirty-nine and nine tenths (39.9) and one (1) or more of the following:

I. Type II diabetes;

II. Cardiovascular disease such as stroke, myocardial infarction, stable or unstable angina pectoris, hypertension, or coronary artery bypass; or

III. Life-threatening cardiopulmonary problems such as severe sleep apnea, Pickwickian syndrome, or obesity-related cardiomyopathy; and

(II) Demonstration that dietary attempts at weight control have been ineffective through completion of a structured diet program. Commercial weight loss programs are acceptable if completed under the direction of a provider or registered dietitian and documentation of participation is available for review. One (1) structured diet program for six (6) consecutive months or two (2) structured diet programs for three (3) consecutive months each within a two- (2-) year period prior to the request for the surgical treatment of morbid obesity are sufficient. Provider-supervised programs consisting exclusively of pharmacological management are not sufficient; and

(III) A thorough multidisciplinary evaluation within the previous twelve (12) months, which include all of the following:

(a) An evaluation by a bariatric surgeon recommending surgical treatment, including a description of the proposed procedure and all of the associated current procedural terminology codes;

(b) A separate medical evaluation from a provider other than the surgeon recommending surgery that includes a medical clearance for bariatric surgery;

(c) Completion of a psychological examination from a mental health provider evaluating the member's readiness and fitness for surgery and the necessary post-operative lifestyle changes. After the evaluation, the mental health provider must provide clearance for bariatric surgery; and

(d) A nutritional evaluation by a provider or registered dietitian;

5. Blood storage. Storage of whole blood, blood plasma, and blood products is covered in conjunction with medical treatment that requires immediate blood transfusion support;

/5./6. Bone Growth Stimulators. Implantable bone growth stimulators are covered as an outpatient surgery benefit. The following nonimplantable bone growth stimulators are covered as a durable medical equipment benefit:

A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)) to accelerate healing

of fresh fractures, fusions, or delayed unions at either of the following high-risk sites:

(I) Fresh fractures, fusions, or delayed unions of the shaft (diaphysis) of the tibia that are open or segmental; or

(II) Fresh fractures, fusions, or delayed unions of the scaphoid (carpal navicular);

B. Ultrasonic osteogenesis stimulator for non-unions, failed arthrodesis, and congenital pseudarthrosis (pseudarthrosis) of the appendicular skeleton if there has been no progression of healing for three (3) or more months despite appropriate fracture care; or

C. Direct current electrical bone-growth stimulator is covered for the following indications:

(I) Delayed unions of fractures or failed arthrodesis at high-risk sites (i.e., open or segmental tibial fractures, carpal navicular fractures);

(II) Non-unions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three (3) or more months despite appropriate fracture care; or

(III) Members who are at high risk for spinal fusion failure when any of the following criteria is met:

(a) A multiple-level fusion entailing three (3) or more vertebrae (e.g., L3 to L5, L4 to S1, etc.);

(b) Grade II or worse spondylolisthesis; or

(c) One (1) or more failed fusions;

[6./7. Contraception and Sterilization. All Food and Drug Administration- (FDA-) approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity;

[7. Blood storage. *Storage of whole blood, blood plasma, and blood products is covered in conjunction with medical treatment that requires immediate blood transfusion support;]*

8. Cardiac rehabilitation. An electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) is covered for specific criteria when it is individually prescribed by a provider and a formal exercise stress test is completed following the event and prior to the initiation of the program. Cardiac rehabilitation is covered for members who meet one (1) of the following criteria:

A. Acute myocardial infarction (MI) (heart attack in the last twelve (12) months);

B. Coronary artery bypass grafting (CABG);

C. Stable angina pectoris;

D. Percutaneous coronary vessel remodeling;

E. Valve replacement or repair;

F. Heart transplant;

G. Coronary artery disease (CAD) associated with chronic stable angina that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities; or

H. Heart failure that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities;

9. Chelation therapy. The administration of FDA-approved chelating agents is covered for any of the following conditions:

A. Genetic or hereditary hemochromatosis;

B. Lead overload in cases of acute or long-term lead exposure;

C. Secondary hemochromatosis due to chronic iron overload due to transfusion-dependent anemias (e.g., Thalassemias, Cooley's anemia, sickle cell anemia, sideroblastic anemia);

D. Copper overload in patients with Wilson's disease;

E. Arsenic, mercury, iron, copper, or gold poisoning when long-term exposure to and toxicity has been confirmed through lab results or clinical findings consistent with metal toxicity;

F. Aluminum overload in chronic hemodialysis patients;

G. Emergency treatment of hypercalcemia;

H. Prophylaxis against doxorubicin-induced cardiomyopathy;

I. Internal plutonium, americium, or curium contamination;

or

J. Cystinuria;

10. Chiropractic services. Chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) are covered when all of the following conditions are met:

A. A neuromusculoskeletal condition is diagnosed that may be relieved by standard chiropractic treatment in order to restore optimal function;

B. Chiropractic care is being performed by a licensed doctor of chiropractic who is practicing within the scope of his/her license as defined by state law;

C. The individual is involved in a treatment program that clearly documents all of the following:

(I) A prescribed treatment program that is expected to result in significant therapeutic improvement over a clearly defined period of time;

(II) The symptoms being treated;

(III) Diagnostic procedures and results;

(IV) Frequency, duration, and results of planned treatment modalities;

(V) Anticipated length of treatment plan with identification of quantifiable, attainable short-term and long-term goals; and

(VI) Demonstrated progress toward significant functional gains and/or improved activity tolerances;

D. Following previous successful treatment with chiropractic care, acute exacerbation or re-injury are covered when all of the following criteria are met:

(I) The member reached maximal therapeutic benefit with prior chiropractic treatment;

(II) The member was compliant with a self-directed home-care program;

(III) Significant therapeutic improvement is expected with continued treatment; and

(IV) The anticipated length of treatment is expected to be short-term (e.g., no more than six (6) visits within a three- (3-) week period);

11. Clinical trials. Routine member care costs incurred as the result of a Phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition are covered when—

A. The study or investigation is conducted under an investigational new drug application reviewed by the FDA; or

B. Is a drug trial that is exempt from having such an investigational new drug application. Life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted; and

C. Routine member care costs include all items and services consistent with the coverage provided in plan benefits that would otherwise be covered for a member not enrolled in a clinical trial. Routine patient care costs do not include the investigational item, device, or service itself; items and services that are provided solely to satisfy data collection and analysis needs and are not used in the direct clinical management of the member; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

D. The member must be eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

E. The clinical trial must be approved or funded by one (1) of the following:

(I) National Institutes of Health (NIH);

(II) Centers for Disease Control and Prevention (CDC);

(III) Agency for Health Care Research and Quality;

(IV) Centers for Medicare & Medicaid Services (CMS);

(V) A cooperative group or center of any of the previously named agencies or the Department of Defense or the Department of Veterans Affairs;

(VI) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for

center support grants; or

(VII) A study or investigation that is conducted by the Department of Veterans Affairs, the Department of Defense, or the Department of Energy and has been reviewed and approved to be comparable to the system of peer review of studies and investigations used by the NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

12. Cochlear implant device. Uniaural (monaural) or binaural (bilateral) cochlear implantation and necessary replacement batteries are covered for a member with bilateral, pre- or post-linguistic, sensorineural, moderate-to-profound hearing impairment when there is reasonable expectation that a significant benefit will be achieved from the device and when the following age-specific criteria are met:

A. Auditory brainstem implant. Auditory brainstem implant (ABI) covered for the diagnosis of neurofibromatosis type II, von Recklinghausen's disease, or when a member is undergoing bilateral removal of tumors of the auditory nerves, and it is anticipated that the member will become completely deaf as a result of the surgery, or the member had bilateral auditory nerve tumors removed and is now bilaterally deaf;

(I) For an adult (age eighteen (18) years or older) with BOTH of the following:

(a) Bilateral, severe to profound sensorineural hearing loss determined by a pure-tone average of seventy (70) decibels (dB) hearing loss or greater at five hundred (500) hertz (Hz), one thousand (1000) Hz, and two thousand (2000) Hz; and

(b) Member has limited benefit from appropriately fitted binaural hearing aids. Limited benefit from amplification is defined by test scores of forty percent (40%) correct or less in best-aided listening condition on open-set sentence cognition (e.g., Central Institute for the Deaf (CID) sentences, Hearing in Noise Test (HINT) sentences, and Consonant-Nucleus-Consonant (CNC) test);

(II) For a child age twelve (12) months to seventeen (17) years, eleven (11) months with both of the following:

(a) Profound, bilateral sensorineural hearing loss with thresholds of ninety (90) dB or greater at one thousand (1000) Hz; and

(b) Limited or no benefit from a three- (3-) month trial of appropriately fitted binaural hearing aids;

(III) For children four (4) years of age or younger, with one (1) of the following:

(a) Failure to reach developmentally appropriate auditory milestones measured using the Infant-Toddler Meaningful Auditory Integration Scale, the Meaningful Auditory Integration Scale, or the Early Speech Perception test; or

(b) Less than twenty percent (20%) correct on open-set word recognition test Multisyllabic Lexical Neighborhood Test (MLNT) in conjunction with appropriate amplification and participation in intensive aural habilitation over a three- (3-) to six- (6-) month period;

(IV) For children older than four (4) years of age with one (1) of the following:

(a) Less than twelve percent (12%) correct on the Phonetically Balanced-Kindergarten Test; or

(b) Less than thirty percent (30%) correct on the HINT for children, the open-set Multisyllabic Lexical Neighborhood Test (MLNT) or Lexical Neighborhood Test (LNT), depending on the child's cognitive ability and linguistic skills; and

(V) A three- (3-) to six- (6-) month hearing aid trial has been undertaken by a child without previous experience with hearing aids;

B. Radiologic evidence of cochlear ossification;

C. The following additional medical necessity criteria must also be met for uniaural (monaural) or binaural (bilateral) cochlear implantation in adults and children:

(I) Member must be enrolled in an educational program that supports listening and speaking with aided hearing;

(II) Member must have had an assessment by an audiologist

and from an otolaryngologist experienced in this procedure indicating the likelihood of success with this device;

(III) Member must have no medical contraindications to cochlear implantation (e.g., cochlear aplasia, active middle ear infection); and

(IV) Member must have arrangements for appropriate follow-up care, including the speech therapy required to take full advantage of this device;

D. A second cochlear implant is covered in the contralateral (opposite) ear as medically necessary in an individual with an existing unilateral cochlear implant when the hearing aid in the contralateral ear produces limited or no benefit;

E. The replacement of an existing cochlear implant is covered when either of the following criteria is met:

(I) Currently used component is no longer functional and cannot be repaired; or

(II) Currently used component renders the implant recipient unable to adequately and/or safely perform his/her age-appropriate activities of daily living; and

F. Post-cochlear or ABI rehabilitation program (aural rehabilitation) is covered to achieve benefit from a covered device;

13. Dental care.

A. Dental care is covered for *[treatment of trauma to the mouth, jaw, teeth, or contiguous sites, as a result of accidental injury.]* the following:

(I) Treatment to reduce trauma and restorative services limited to dental implants only when the result of accidental injury to sound natural teeth and tissue that are viable, functional, and free of disease. **Treatment must be initiated within sixty (60) days of accident; and**

(II) Restorative services limited to dental implants when needed as a result of cancerous or non-cancerous tumors and cysts, cancer, and post-surgical sequelae.

B. The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization when provided in a network or non-network hospital or surgical center;

14. Diabetes **self-management training**/E/education when prescribed by a provider and taught by a Certified Diabetes Educator through a medical network provider;

15. Dialysis is covered when received through a network provider;

/15./16. Durable medical equipment (DME) is covered when ordered by a provider to treat an injury or illness. DME includes, but is not limited to, the following:

A. Insulin pumps;

B. Oxygen;

C. Augmentative communication devices;

D. Manual and powered mobility devices;

E. Disposable supplies that do not withstand prolonged use and are periodically replaced, including, but not limited to, the following:

(I) Colostomy and ureterostomy bags;

(II) Prescription compression stockings limited to two (2) pairs or four (4) individual stockings per plan year;

F. Blood pressure cuffs/monitors with a diagnosis of diabetes;

G. Repair and replacement of DME is covered when any of the following criteria are met:

(I) Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

(II) Routine wear and tear of the equipment renders it non-functional and the member still requires the equipment; or

(III) The provider has documented that the condition of the member changes or if growth-related;

/16./17. Emergency room services. Coverage is for emergency medical conditions. If a member is admitted to the hospital, s/he may be required to transfer to network facility for maximum benefit.

Hospital and ancillary charges are paid as a network benefit;

[17./18. Eye glasses and contact lenses. Coverage limited to charges incurred in connection with the fitting of eye glasses or contact lenses for initial placement within one (1) year following cataract surgery;

[18./19. Foot care (trimming of nails, corns, or calluses). Foot care services are covered when administered by a provider and—

A. When associated with systemic conditions that are significant enough to result in severe circulatory insufficiency or areas of desensitization in the lower extremities including, but not limited to, any of the following:

- (I) Diabetes mellitus;
- (II) Peripheral vascular disease; or
- (III) Peripheral neuropathy.

(IV) Evaluation/debridement of mycotic nails, in the absence of a systemic condition, when both of the following conditions are met:

(a) Pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate; and

(b) If the member is ambulatory, pain markedly limits ambulation;

[19./20. Genetic counseling. Pre-test and post-test genetic counseling with a provider or a licensed or certified genetic counselor are covered when a member is recommended for covered heritable genetic testing.

A. Genetic counseling in connection with pregnancy management is covered only for evaluation of any of the following:

(I) Couples who are closely related genetically (e.g., consanguinity, incest);

(II) Familial cancer disorders;

(III) Individuals recognized to be at increased risk for genetic disorders;

(IV) Infertility cases where either parent is known to have a chromosomal abnormality;

(V) Primary amenorrhea, [azospermia] **azoospermia**, abnormal sexual development, or failure in developing secondary sexual characteristics;

(VI) Mother is a known, or presumed carrier of an X linked recessive disorder;

(VII) One (1) or both parents are known carriers of an autosomal recessive disorder;

(VIII) Parents of a child born with a genetic disorder, birth defect, inborn error of metabolism, or chromosome abnormality;

(IX) Parents of a child with intellectual developmental disorders, autism, developmental delays, or learning disabilities;

(X) Pregnant women who, based on prenatal ultrasound tests or an abnormal multiple marker screening test, maternal serum alpha-fetoprotein (AFP) test, test for sickle cell anemia, or tests for other genetic abnormalities have been told their pregnancy may be at increased risk for complications or birth defects;

(XI) Pregnant women age thirty-five (35) years or older at delivery;

(XII) Pregnant women, or women planning pregnancy, exposed to potentially teratogenic, mutagenic, or carcinogenic agents such as chemicals, drugs, infections, or radiation;

(XIII) Previous unexplained stillbirth or repeated (three (3) or more; two (2) or more among infertile couples) first-trimester miscarriages, where there is suspicion of parental or fetal chromosomal abnormalities; or

(XIV) When contemplating pregnancy, either parent affected with an autosomal dominant disorder;

[20./21. Genetic testing.

A. Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following criteria are met:

(I) The member displays clinical features or is at direct risk of inheriting the mutation in question (pre-symptomatic);

(II) The result of the test will directly impact the treatment being delivered to the member;

(III) The testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and

(IV) After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain;

B. Genetic testing for the breast cancer susceptibility gene (BRCA) when family history is present;

[21./22. Hair analysis. Chemical hair analysis is covered for the diagnosis of suspected chronic arsenic poisoning. Other purposes are considered experimental and investigational;

[22./23. Hair prostheses. Prostheses and expenses for scalp hair prostheses worn for hair loss are covered for alopecia areata or alopecia totalis for children eighteen (18) years of age or younger. The annual maximum is two hundred dollars (\$200), and the lifetime maximum is three thousand two hundred dollars (\$3,200);

[23./24. Hearing aids (per ear). Hearing aids covered for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss.

A. Prior to receiving a hearing aid members must receive—

(I) A medical exam by a physician or other qualified provider to identify any medically treatable conditions that may affect hearing; and

(II) A comprehensive hearing test to assess the need for hearing aids conducted by a certified audiologist, hearing instrument specialist, or other provider licensed or certified to administer this test.

B. Covered once every two (2) years. If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

(I) Conventional: one thousand dollars (\$1,000).

(II) Programmable: two thousand dollars (\$2,000).

(III) Digital: two thousand five hundred dollars (\$2,500).

(IV) Bone Anchoring Hearing Aid (BAHA): three thousand five hundred dollars (\$3,500);

[24./25. Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by provider;

[25./26. Home health care. Skilled home health nursing care is covered for members who are homebound because of injury or illness (i.e., the member leaves home only with considerable and taxing effort, and absences from home are infrequent or of short duration, or to receive medical care). Services must be performed by a registered nurse or licensed practical nurse, licensed therapist, or a registered dietitian. Covered services include:

A. Home visits instead of visits to the provider's office that do not exceed the usual and customary charge to perform the same service in a provider's office;

B. Intermittent nurse services. Benefits are paid for only one (1) nurse at any one (1) time, not to exceed four (4) hours per twenty-four- (24-) hour period;

C. Nutrition counseling provided by or under the supervision of a registered dietitian;

D. Physical, occupational, respiratory, and speech therapy provided by or under the supervision of a licensed therapist;

E. Medical supplies, drugs or medication prescribed by provider, and laboratory services to the extent that the plan would have covered them under this plan if the covered person had been in a hospital;

F. A home health care visit is defined as—

(I) A visit by a nurse providing intermittent nurse services (each visit includes up to a four- (4-) hour consecutive visit in a twenty-four- (24-) hour period if clinical eligibility for coverage is met) or a single visit by a therapist or a registered dietitian; and

G. Benefits cannot be provided for any of the following:

(I) Homemaker or housekeeping services;

(II) Supportive environment materials such as handrails, ramps, air conditioners, and telephones;

(III) Services performed by family members or volunteer workers;

(IV) "Meals on Wheels" or similar food service;

(V) Separate charges for records, reports, or transportation;

(VI) Expenses for the normal necessities of living such as food, clothing, and household supplies; and

(VII) Legal and financial counseling services, unless otherwise covered under this plan;

[26.]27. Hospice care and palliative services (inpatient or outpatient). Includes bereavement and respite care. Hospice care services, including pre-hospice evaluation or consultation, are covered when the individual is terminally ill and expected to live six (6) months or less, potentially curative treatment for the terminal illness is not part of the prescribed plan of care, the individual or appointed designee has formally consented to hospice care (i.e., care directed mostly toward palliative care and symptom management), and the hospice services are provided by a certified/accredited hospice agency with care available twenty-four (24) hours per day, seven (7) days per week.

A. When the above criteria are met, the following hospice care services are covered:

(I) Assessment of the medical and social needs of the terminally ill person, and a description of the care to meet those needs;

(II) Inpatient care in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy, and part-time home health care services;

(III) Outpatient care for other services as related to the terminal illness, which include services of a physician, physical or occupational therapy, and nutrition counseling provided by or under the supervision of a registered dietitian; and

(IV) Bereavement counseling benefits which are received by a member's close relative when directly connected to the member's death and bundled with other hospice charges. The services must be furnished within twelve (12) months of death;

[27.]28. Hospital (includes inpatient, outpatient, and surgical centers).

A. The following benefits are covered:

(I) Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a covered expense only when clinical eligibility for coverage is met. If the hospital has no semi-private rooms, the plan will allow the private room rate subject to usual, customary, and reasonable charges or the network rate, whichever is applicable;

(II) Intensive care unit room and board;

(III) Surgery, therapies, and ancillary services including, but not limited to:

(a) Cornea transplant;

(b) Coverage for breast reconstruction surgery or prostheses following mastectomy and lumpectomy is available to both females and males. A diagnosis of breast cancer is not required for breast reconstruction services to be covered, and the timing of reconstructive services is not a factor in coverage;

(c) Sterilization for the purpose of birth control is covered;

(d) Cosmetic/reconstructive surgery is covered to repair a functional disorder caused by disease or injury;

(e) Cosmetic/reconstructive surgery is covered to repair a congenital defect or abnormality for a member younger than nineteen (19) years; and

(f) Blood, blood plasma, and plasma expanders are covered, when not available without charge;

(IV) Inpatient mental health services are covered when authorized by a physician for treatment of a mental health disorder. Inpatient mental health services are covered, subject to all of the following:

(a) Member must be ill in more than one (1) area of daily living to such an extent that s/he is rendered dysfunctional and requires the intensity of an inpatient setting for treatment. Without such inpatient treatment, the member's condition would deteriorate;

(b) The member's mental health disorder must be treatable in an inpatient facility;

(c) The member's mental health disorder must meet diagnostic criteria as described in the most recent edition of the *American Psychiatric Association Diagnostic and Statistical Manual (DSM)*. If outside of the United States, the member's mental health disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region;

(d) The attending provider must be a psychiatrist. If the admitting provider is not a psychiatrist, a psychiatrist must be attending to the member within twenty-four (24) hours of admittance. Such psychiatrist must be United States board-eligible or board-certified. If outside of the United States, inpatient services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending provider must meet the requirements, if any, set out by the foreign government or regionally-recognized licensing body for treatment of mental health disorders;

(e) Day treatment (partial hospitalization) for mental health services means a day treatment program that offers intensive, multidisciplinary services provided on less than a full-time basis. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such programs must be a less-restrictive alternative to inpatient treatment; and

(f) Mental health services received in a residential treatment facility that is licensed by the state in which it operates and provides treatment for mental health disorders is covered. This does not include services provided at a group home. If outside of the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and

(V) Outpatient mental health services are covered if the member is at a therapeutic medical or mental health facility and treatment includes measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident. Treatment must be provided by one (1) of the following:

(a) A United States board-eligible or board-certified psychiatrist licensed in the state where the treatment is provided;

(b) A therapist with a doctorate or master's degree that denotes a specialty in psychiatry (Psy.D.);

(c) A state-licensed psychologist;

(d) A state-licensed or certified social worker practicing within the scope of his or her license or certification; or

(e) Licensed professional counselor;

29. Infusions are covered when received through a network provider. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered are not a medical plan benefit but are covered as part of the pharmacy benefit;

[28.]30. Injections [and infusions. Injections and infusions are covered]. See preventive services for coverage of *[immunizations] vaccinations*. See contraception and sterilization for coverage of birth control injections. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered/, *including injectables,* are not a medical plan benefit but are covered as part of the pharmacy benefit.

A. B12 injections are covered for the following conditions:

(I) Pernicious anemia;

(II) Crohn's disease;

(III) Ulcerative colitis;

(IV) Inflammatory bowel disease;

(V) Intestinal malabsorption;

(VI) Fish tapeworm anemia;

(VII) Vitamin B12 deficiency;

(VIII) Other vitamin B12 deficiency anemia;

(IX) Macrocytic anemia;

(X) Other specified megaloblastic anemias;

- (XI) Megaloblastic anemia;
- (XII) Malnutrition of alcoholism;
- (XIII) Thrombocytopenia, unspecified;
- (XIV) Dementia in conditions classified elsewhere;
- (XV) Polyneuropathy in diseases classified elsewhere;
- (XVI) Alcoholic polyneuropathy;
- (XVII) Regional enteritis of small intestine;
- (XVIII) Postgastric surgery syndromes;
- (XIX) Other prophylactic chemo-therapy;
- (XX) Intestinal bypass or anastomosis status;
- (XXI) Acquired absence of stomach;
- (XXII) Pancreatic insufficiency; and
- (XXIII) Ideopathic progressive polyneuropathy;

[29./31. Lab, X-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition. Professional charges for automated lab services performed by an out-of-network provider are not covered;

[30./32. Maternity coverage. Prenatal and postnatal care is covered. Routine prenatal office visits and screenings recommended by the Health Resources and Services Administration are covered at one hundred percent (100%). Other care is subject to the deductible and coinsurance. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after vaginal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post discharge care that shall consist of a two- (2-) visit minimum, at least one (1) in the home;

[31./33. Nutritional counseling. Individualized nutritional evaluation and counseling for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program is covered when ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian);

[32./34. Nutrition therapy.

A. Nutrition therapy is covered only when the following criteria are met:

- (I) Nutrition therapy is the sole source of nutrients or a significant percentage of the daily caloric intake;
- (II) Nutrition therapy is used in the treatment of, or in association with, a demonstrable disease, condition, or disorder;
- (III) Nutrition therapy is necessary to sustain life or health;
- (IV) Nutrition therapy is prescribed by a provider; and
- (V) Nutrition therapy is managed, monitored, and evaluated on an on-going basis, by a provider.

B. Only the following types of nutrition therapy are covered:

(I) Enteral Nutrition (EN). EN is the provision of nutritional requirements via the gastrointestinal tract. EN can be taken orally or through a tube into the stomach or small intestine;

(II) Parenteral Nutrition Therapy (PN) and Total Parenteral Nutrition (TPN). PN is liquid nutrition administered through a vein to provide part of daily nutritional requirements. TPN is a type of PN that provides all daily nutrient needs. PN or TPN are covered when the member's nutritional status cannot be adequately maintained on oral or enteral feedings;

(III) Intradialytic Parenteral Nutrition (IDPN). IDPN is a type of PN that is administered to members on chronic hemodialysis during dialysis sessions to provide most nutrient needs. IDPN is covered when the member is on chronic hemodialysis and nutritional status cannot be adequately maintained on oral or enteral feedings;

[33./35. Office visit. Member encounter with a provider for health care, mental health, or substance use disorder in an office, clinic, or ambulatory care facility is covered based on the service, procedure, or related treatment plan;

[34./36. Oral surgery is covered for injury, tumors, or cysts. Oral surgery includes, but is not limited to, reduction of fractures and dislocation of the jaws; external incision and drainage of cellulites; incision of accessory sinuses, salivary glands, or ducts; excision of exostosis of jaws and hard palate; and frenectomy. Treatment must be

initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. Extractions of bony or partial bony impactions are excluded;

[35./37. Orthognathic or Jaw Surgery. Orthognathic or jaw surgery is covered when one (1) of the following conditions is documented and diagnosed:

- A. Acute traumatic injury, and post-surgical sequela;
- B. Cancerous or non-cancerous tumors and cysts, cancer, and post-surgical sequela;
- C. Cleft lip/palate (for cleft lip/palate related jaw surgery); or
- D. Physical or physiological abnormality when one (1) of the following criteria is met:

(I) Anteroposterior Discrepancies—

- (a) Maxillary/Mandibular incisor relationship: over jet of 5mm or more, or a 0 to a negative value (norm 2mm);
- (b) Maxillary/Mandibular anteroposterior molar relationship discrepancy of 4mm or more (norm 0 to 1mm); or
- (c) These values represent two (2) or more standard deviation from published norms;

(II) Vertical Discrepancies—

- (a) Presence of a vertical facial skeletal deformity which is two (2) or more standard deviations from published norms for accepted skeletal landmarks;
- (b) Open bite with no vertical overlap of anterior teeth or unilateral or bilateral posterior open bite greater than 2mm;
- (c) Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch; or
- (d) Supraeruption of a dentoalveolar segment due to lack of occlusion;

(III) Transverse Discrepancies—

- (a) Presence of a transverse skeletal discrepancy which is two (2) or more standard deviations from published norms; or
- (b) Total bilateral maxillary palatal cusp to mandibular-fossa discrepancy of 4mm or greater, or a unilateral discrepancy of 3mm or greater, given normal axial inclination of the posterior teeth; or

(IV) Asymmetries—

- (a) Anteroposterior, transverse, or lateral asymmetries greater than 3mm with concomitant occlusal asymmetry;
- (V) Masticatory (chewing) and swallowing dysfunction due to malocclusion (e.g., inability to incise or chew solid foods, choking on incompletely masticated solid foods, damage to soft tissue during mastication, malnutrition);
- (VI) Speech impairment; or
- (VII) Obstructive sleep apnea or airway dysfunction;

[36./38. Orthotics.

A. Ankle-Foot Orthosis (AFO) and Knee-Ankle-Foot Orthosis (KAFO).

(I) Basic coverage criteria for AFO and KAFO used during ambulation are as follows:

(a) AFO is covered when used in ambulation for members with weakness or deformity of the foot and ankle, which require stabilization for medical reasons, and have the potential to benefit functionally;

(b) KAFO is covered when used in ambulation for members when the following criteria are met:

- I. Member is covered for AFO; and
- II. Additional knee stability is required; and
- (c) AFO and KAFO that are molded-to-patient-model, or custom-fabricated, are covered when used in ambulation, only when the basic coverage criteria and one (1) of the following criteria are met:

- I. The member could not be fitted with a prefabricated AFO;
- II. AFO or KAFO is expected to be permanent or for more than six (6) months duration;
- III. Knee, ankle, or foot must be controlled in more than one (1) plane;

IV. There is documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or

V. The member has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

(II) AFO and KAFO Not Used During Ambulation.

(a) AFO and KAFO not used in ambulation are covered if the following criteria are met:

I. Passive range of motion test was measured with goniometer and documented in the medical record;

II. Documentation of an appropriate stretching program administered under the care of provider or caregiver;

III. Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least ten degrees (10°) (i.e., a non-fixed contracture);

IV. Reasonable expectation of the ability to correct the contracture;

V. Contracture is interfering or expected to interfere significantly with the patient's functional abilities; and

VI. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons; or

VII. Member has plantar fasciitis.

(b) Replacement interface for AFO or KAFO is covered only if member continues to meet coverage criteria and is limited to a maximum of one (1) per six (6) months.

B. Cast Boot, Post-Operative Sandal or Shoe, or Healing Shoe. A cast boot, post-operative sandal or shoe, or healing shoe is covered for one (1) of the following indications:

(I) To protect a cast from damage during weight-bearing activities following injury or surgery;

(II) To provide appropriate support and/or weight-bearing surface to a foot following surgery;

(III) To promote good wound care and/or healing via appropriate weight distribution and foot protection; or

(IV) When the patient is currently receiving treatment for lymphedema and the foot cannot be fitted into conventional footwear.

C. Cranial Orthoses. Cranial orthosis is covered for Synostotic and Non-Synostotic Plagiocephaly. Plagiocephaly is an asymmetrically shaped head. Synostotic Plagiocephaly is due to premature closure of cranial sutures. Non-Synostotic Plagiocephaly is from positioning or deformation of the head. Cranial orthosis is the use of a special helmet or band on the head which aids in molding the shape of the cranium to normal. Initial reimbursement shall cover any subsequent revisions.

D. Elastic Supports. Elastic supports are covered when prescribed for one (1) of the following indications:

(I) Severe or incapacitating vascular problems, such as acute thrombophlebitis, massive venous stasis, or pulmonary embolism;

(II) Venous insufficiency;

(III) Varicose veins;

(IV) Edema of lower extremities;

(V) Edema during pregnancy; or

(VI) Lymphedema.

E. Footwear Incorporated Into a Brace for Members with Skeletally Mature Feet. Footwear incorporated into a brace must be billed by the same supplier billing for the brace. The following types of footwear incorporated into a brace are covered:

(I) Orthopedic footwear;

(II) Other footwear such as high top, depth inlay, or custom;

(III) Heel replacements, sole replacements, and shoe transfers involving shoes on a brace;

(IV) Inserts for a shoe that is an integral part of a brace and are required for the proper functioning of the brace; or

(V) Other shoe modifications if they are on a shoe that is an integral part of a brace and are required for the proper functioning of the brace.

F. Foot Orthoses. Custom, removable foot orthoses are covered for members who meet the following criteria:

(I) Member with skeletally mature feet who has any of the following conditions:

(a) Acute plantar fasciitis;

(b) Acute sport-related injuries with diagnoses related to inflammatory problems such as bursitis or tendonitis;

(c) Calcaneal bursitis (acute or chronic);

(d) Calcaneal spurs (heel spurs);

(e) Conditions related to diabetes;

(f) Inflammatory conditions (e.g., sesamoiditis, sub-metatarsal bursitis, synovitis, tenosynovitis, synovial cyst, osteomyelitis, and plantar fascial fibromatosis);

(g) Medial osteoarthritis of the knee;

(h) Musculoskeletal/arthropathic deformities including deformities of the joint or skeleton that impairs walking in a normal shoe (e.g., bunions, hallux valgus, talipes deformities, pes deformities, or anomalies of toes);

(i) Neurologically impaired feet including neuroma, tarsal tunnel syndrome, ganglionic cyst;

(j) Neuropathies involving the feet, including those associated with peripheral vascular disease, diabetes, carcinoma, drugs, toxins, and chronic renal disease; or

(k) Vascular conditions including ulceration, poor circulation, peripheral vascular disease, Buerger's disease (thromboangiitis obliterans), and chronic thrombophlebitis;

(II) Member with skeletally immature feet who has any of the following conditions:

(a) Hallux valgus deformities;

(b) In-toe or out-toe gait;

(c) Musculoskeletal weakness such as pronation or pes planus;

(d) Structural deformities such as tarsal coalitions; or

(e) Torsional conditions such as metatarsus adductus, tibial torsion, or femoral torsion.

G. Helmets. Helmets are covered when cranial protection is required due to a documented medical condition that makes the member susceptible to injury during activities of daily living.

H. Hip Orthosis. Hip orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the hip;

(II) To facilitate healing following an injury to the hip or related soft tissues;

(III) To facilitate healing following a surgical procedure of the hip or related soft tissue; or

(IV) To otherwise support weak hip muscles or a hip deformity.

I. Knee Orthosis. Knee orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the knee;

(II) To facilitate healing following an injury to the knee or related soft tissues;

(III) To facilitate healing following a surgical procedure on the knee or related soft tissue; or

(IV) To otherwise support weak knee muscles or a knee deformity.

J. Orthopedic Footwear for Diabetic Members.

(I) Orthopedic footwear, therapeutic shoes, inserts, or modifications to therapeutic shoes are covered for diabetic members if any following criteria are met:

(a) Previous amputation of the other foot or part of either foot;

(b) History of previous foot ulceration of either foot;

(c) History of pre-ulcerative calluses of either foot;

(d) Peripheral neuropathy with evidence of callus formation of either foot;

(e) Foot deformity of either foot; or

(f) Poor circulation in either foot.

(II) Coverage is limited to one (1) of the following within

one (1) year:

(a) One (1) pair of custom molded shoes (which includes inserts provided with these shoes) and two (2) additional pairs of inserts;

(b) One (1) pair of depth shoes and three (3) pairs of inserts (not including the non-customized removable inserts provided with such shoes); or

(c) Up to three (3) pairs of inserts not dispensed with diabetic shoes if the supplier of the shoes verifies in writing that the patient has appropriate footwear into which the insert can be placed.

K. Orthotic-Related Supplies. Orthotic-related supplies are covered when necessary for the function of the covered orthotic device.

L. Spinal Orthoses. A thoracic-lumbar-sacral orthosis, lumbar orthosis, lumbar-sacral orthosis, and cervical orthosis are covered for the following indications:

(I) To reduce pain by restricting mobility of the trunk;

(II) To facilitate healing following an injury to the spine or related soft tissues;

(III) To facilitate healing following a surgical procedure of the spine or related soft tissue; or

(IV) To otherwise support weak spinal muscles or a deformed spine.

M. Trusses. Trusses are covered when a hernia is reducible with the application of a truss.

N. Upper Limb Orthosis. Upper limb orthosis is covered for the following indications:

(I) To reduce pain by restricting mobility of the joint(s);

(II) To facilitate healing following an injury to the joint(s) or related soft tissues; or

(III) To facilitate healing following a surgical procedure of the joint(s) or related soft tissue.

O. Orthotic Device Replacement. When repairing an item that is no longer cost-effective and is out of warranty, the plan will consider replacing the item subject to review of medical necessity and life expectancy of the device;

[37.]39. Preventive services.

A. Services recommended by the U.S. Preventive Services Task Force (categories A and B).

B. *[Immunizations]* **Vaccinations** recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

C. Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration.

D. Preventive care and screenings for women supported by the Health Resources and Services Administration.

E. Preventive exams and other services ordered as part of the exam. For benefits to be covered as preventive, they must be coded by the provider as routine, without indication of an injury or illness.

F. Cancer screenings. One (1) per calendar year. Additional screenings beyond one (1) per calendar year covered as diagnostic unless otherwise specified—

(I) Mammograms—no age limit. Standard two-dimensional (2D) breast mammography and breast tomosynthesis (three-dimensional (3D) mammography);

(II) Pap smears—no age limit;

(III) Prostate—no age limit; and

(IV) Colorectal screening—no age limit.

G. *[Zoster vaccination (shingles)—The zoster vaccine is covered for members age fifty (50) years and older]* **Online weight management program offered through the plan's exclusive provider arrangement;**

[38.]40. Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement is covered due to normal wear and tear, if there is a change in medical condition, or if growth-related;

[39.]41. Pulmonary rehabilitation. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for

pre- and post-operative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

A. Member has a reduction of exercise tolerance that restricts the ability to perform activities of daily living (ADL) or work;

B. Member has chronic pulmonary disease (including asthma, emphysema, chronic bronchitis, chronic airflow obstruction, cystic fibrosis, alpha-1 antitrypsin deficiency, pneumoconiosis, asbestosis, radiation pneumonitis, pulmonary fibrosis, pulmonary alveolar proteinosis, pulmonary hemosiderosis, fibrosing alveolitis), or other conditions that affect pulmonary function such as ankylosing spondylitis, scoliosis, myasthenia gravis, muscular dystrophy, Guillain-Barré syndrome, or other infective polyneuritis, sarcoidosis, paralysis of diaphragm, or bronchopulmonary dysplasia; and

C. Member has a moderate to moderately severe functional pulmonary disability, as evidenced by either of the following, and does not have any concomitant medical condition that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g., symptomatic coronary artery disease, congestive heart failure, myocardial infarction within the last six (6) months, dysrhythmia, active joint disease, claudication, malignancy):

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake ($\text{VO}_{2\text{max}}$) equal to or less than twenty milliliters per kilogram per minute (20 mL/kg/min), or about five (5) metabolic equivalents (METS); or

(II) Pulmonary function tests showing that either the Forced Expiratory Volume in One Second (FEV1), Forced Vital Capacity (FVC), FEV1/FVC, or Diffusing Capacity of the Lung for Carbon Monoxide (DLCO) is less than sixty percent (60%) of that predicted;

[40.]42. Skilled Nursing Facility. Skilled nursing facility services are covered up to one hundred twenty (120) days per calendar year;

[41.]43. Telehealth Services. Telehealth services are covered for the diagnosis, consultation, or treatment of a member on the same basis that the service would be covered when it is delivered in person;

[42.]44. Therapy. Physical, occupational, and speech therapy are covered when prescribed by a provider and subject to the provisions below:

A. Physical therapy.

(I) Physical therapy must meet the following criteria:

(a) The program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, congenital defect, or surgery;

(b) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(c) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

B. Occupational therapy must meet the following criteria:

(I) The program is designed to improve or compensate for lost or impaired physical functions, particularly those affecting activities of daily living, resulting from illness, injury, congenital defect, or surgery;

(II) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(III) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

C. Speech therapy.

(I) All of the following criteria must be met for coverage of speech therapy:

(a) The therapy requires one-to-one intervention and supervision of a speech-language pathologist;

(b) The therapy plan includes specific tests and measures that will be used to document significant progress every two (2) weeks;

(c) Meaningful improvement is expected;

(d) The therapy includes a transition from one-to-one

supervision to a self- or caregiver- provided maintenance program upon discharge; and

(e) One (1) of the following:

I. Member has severe impairment of speech-language; and an evaluation has been completed by a certified speech-language pathologist that includes age-appropriate standardized tests to measure the extent of the impairment, performance deviation, and language and pragmatic skill assessment levels; or

II. Member has a significant voice disorder that is the result of anatomic abnormality, neurological condition, or injury (e.g., vocal nodules or polyps, vocal cord paresis or paralysis, post-operative vocal cord surgery);

[43.]45. Transplants. Stem cell, kidney, liver, heart, lung, pancreas, small bowel, or any combination are covered. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements.

A. Network includes travel and lodging allowance for the transplant recipient and an immediate family travel companion when the transplant facility is more than fifty (50) miles from the recipient's residence. If the recipient is younger than age nineteen (19) years, travel and lodging is covered for both parents. The transplant recipient must be with the travel companion or parent(s) for the travel companion's or parent(s)' travel expense to be reimbursable. Combined travel and lodging expenses are limited to a ten thousand dollar (\$10,000) maximum per transplant.

(I) Lodging—maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to www.gsa.gov for per diem rates.

(II) Travel—IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).

(III) Meals—not covered.

B. Non-network. Charges above the maximum for services rendered at a non-network facility are the member's responsibility and do not apply to the member's deductible or out-of-pocket maximum. Travel, lodging, and meals are not covered;

[44.]46. Urgent care. Member encounter with a provider for urgent care is covered based on the service, procedure, or related treatment plan; and

[45.]47. Vision. One (1) routine exam and refraction is covered per calendar year.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed amendment covering this same material is published in this issue of the Missouri Register.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

EMERGENCY RULE

22 CSR 10-3.058 PPO 750 Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 750 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency rule is necessary to serve a compelling

governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule to maintain the integrity of the current health care plan. This emergency rule fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the Missouri Register. This emergency rule complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.

(1) Deductible—per calendar year for network: per individual, seven hundred fifty dollars (\$750); family, one thousand five hundred dollars (\$1,500) and for non-network: per individual, one thousand five hundred dollars (\$1,500); family, three thousand dollars (\$3,000).

(A) Network and non-network deductibles are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Claims will not be paid until the applicable deductible is met.

(C) Services that do not apply to the deductible and for which applicable costs will continue to be charged include, but are not limited to: copayments, charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(D) The family deductible is an embedded deductible with two (2) parts: an individual deductible and an overall family deductible. Each family member must meet his/her own individual deductible amount until the overall family deductible amount is reached. Once a family member meets his/her own individual deductible, the plan will start to pay claims for that individual and any additional out-of-pocket expenses incurred by that individual will not be used to meet the family deductible amount. Once the overall family deductible is met, the plan will start to pay claims for the entire family even if some family members have not met his/her own individual deductible.

(2) Coinsurance—coinsurance amounts apply to covered services after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(A) Network claims are paid at eighty percent (80%) until the out-of-pocket maximum is met.

(B) Non-network claims are paid at sixty percent (60%) until the out-of-pocket maximum is met.

(3) Out-of-pocket maximum—per calendar year for network: per individual, two thousand two hundred fifty dollars (\$2,250); family, four thousand five hundred dollars (\$4,500) and for non-network: per individual, four thousand five hundred dollars (\$4,500); family, nine thousand dollars (\$9,000).

(A) Network and non-network out-of-pocket maximums are separate. Expenses cannot be shared or transferred between network and

non-network benefits.

(B) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include, but are not limited to: charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(C) The family out-of-pocket maximum is an embedded out-of-pocket maximum with two (2) parts: an individual out-of-pocket maximum and an overall family out-of-pocket maximum. Each family member must meet his/her own individual out-of-pocket maximum amount until the overall family out-of-pocket maximum amount is reached. Once a family member meets his/her own individual out-of-pocket maximum, the plan will start to pay claims at one hundred percent (100%) for that individual. Once the overall family out-of-pocket maximum is met, the plan will start to pay claims at one hundred percent (100%) for the entire family even if some family members had not met his/her own individual out-of-pocket maximum.

(4) The following services will be paid as a network benefit when provided by a non-network provider:

(A) Emergency services and urgent care;

(B) Covered services that are not available through a network provider within one hundred (100) miles of the member's home. The member must contact the claims administrator before the date of service in order to have a closer non-network provider's claims approved as a network benefit. Such approval is for three (3) months. After three (3) months, the member must contact the claims administrator to reassess network availability;

(C) Covered services when such services are provided in a network hospital or ambulatory surgical center and are an adjunct to a service being performed by a network provider. Examples of such adjunct services include, but are not limited to, anesthesiology, assistant surgeon, pathology, or radiology.

(5) The following services are not subject to deductible, coinsurance, or copayment requirements and will be paid at one hundred percent (100%) when provided by a network provider:

(A) Preventive care;

(B) Nutrition counseling;

(C) A newborn's initial hospitalization until discharge or transfer to another facility if the mother is a Missouri Consolidated Health Care Plan (MCHCP) member at the time of birth; and

(D) Four (4) Diabetes Self-Management Education/Training visits with a certified diabetes educator when ordered by a provider.

(6) Influenza vaccinations provided by a non-network provider will be reimbursed up to twenty-five dollars (\$25) once the member submits a receipt and a reimbursement form to the claims administrator.

(7) Married, active employees who are MCHCP subscribers and have enrolled children may meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must provide the other spouse's Social Security number (SSN) and report the other spouse as eligible for coverage when newly hired and during the open enrollment process. In the medical plan vendor and pharmacy benefit manager system, the spouse with children enrolled will be considered the subscriber and the spouse that does not have children enrolled will be considered a dependent. If both spouses have children enrolled the spouse with the higher Social Security number (SSN) will be considered the subscriber. Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

(8) Each subscriber will have access to payment information of the family unit only when authorization is granted by the adult covered dependent(s).

(9) Expenses toward the deductible and out-of-pocket maximum will be transferred if the member changes non-Medicare medical plans during the plan year or continues enrollment under another subscriber's non-Medicare medical plan within the same plan year.

(10) Copayments.

(A) Emergency room—two hundred fifty dollars (\$250) network and non-network. Deductible and coinsurance requirements apply to emergency room services in addition to the copayment. If a member is admitted to the hospital or the claims administrator considers the claim to be for a true emergency, the copayment is waived.

(B) Inpatient hospitalization—two hundred dollars (\$200) per admission for network and non-network. Deductible and coinsurance requirements apply to inpatient hospitalization services in addition to the copayment.

(11) Maximum plan payment—non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed at one hundred ten percent (110%) of Medicare reimbursement. Members may be held liable for the amount of the fee above the allowed amount.

(12) Any claim must be initially submitted within twelve (12) months following the date of service. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

(13) For a member who is an inpatient on the last calendar day of a plan year and remains an inpatient into the next plan year, the prior plan year's applicable copayment, deductible, and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

(14) Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-2.055. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as a non-network benefit. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

(15) Medicare.

(A) When MCHCP becomes aware that the member is eligible for Medicare benefits, claims will be processed reflecting Medicare coverage.

(B) If a member does not enroll in Medicare when s/he is eligible and Medicare should be the member's primary plan, the member will be responsible for paying the portion Medicare would have paid. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

(C) If a Medicare primary member chooses a provider who has opted out of Medicare, the member will be responsible for paying the portion Medicare would have paid if the service was performed by a Medicare provider. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating

subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed rule covering this same material is published in this issue of the Missouri Register.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

EMERGENCY RULE

22 CSR 10-3.059 PPO 1250 Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 1250 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency rule is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule to maintain the integrity of the current health care plan. This emergency rule fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the Missouri Register. This emergency rule complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.

(1) Deductible—per calendar year for network: per individual, one thousand two hundred fifty dollars (\$1,250); family, two thousand five hundred dollars (\$2,500) and for non-network: per individual, two thousand five hundred dollars (\$2,500); family, five thousand dollars (\$5,000).

(A) Network and non-network deductibles are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Claims will not be paid until the applicable deductible is met.

(C) Services that do not apply to the deductible and for which applicable costs will continue to be charged include, but are not limited to: copayments, charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompli-

ance; non-covered services and charges above the maximum allowed.

(D) The family deductible is an embedded deductible with two (2) parts: an individual deductible and an overall family deductible. Each family member must meet his/her own individual deductible amount until the overall family deductible amount is reached. Once a family member meets his/her own individual deductible, the plan will start to pay claims for that individual and any additional out-of-pocket expenses incurred by that individual will not be used to meet the family deductible amount. Once the overall family deductible is met, the plan will start to pay claims for the entire family even if some family members have not met his/her own individual deductible.

(2) Coinsurance—coinsurance amounts apply to covered services after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(A) Network claims are paid at eighty percent (80%) until the out-of-pocket maximum is met.

(B) Non-network claims are paid at sixty percent (60%) until the out-of-pocket maximum is met.

(3) Out-of-pocket maximum—per calendar year for network: per individual, three thousand seven hundred fifty dollars (\$3,750); family, seven thousand five hundred dollars (\$7,500) and for non-network: per individual, seven thousand five hundred dollars (\$7,500); family, fifteen thousand dollars (\$15,000).

(A) Network and non-network out-of-pocket maximums are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include, but are not limited to: charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(C) The family out-of-pocket maximum is an embedded out-of-pocket maximum with two (2) parts: an individual out-of-pocket maximum and an overall family out-of-pocket maximum. Each family member must meet his/her own individual out-of-pocket maximum amount until the overall family out-of-pocket maximum amount is reached. Once a family member meets his/her own individual out-of-pocket maximum, the plan will start to pay claims at one hundred percent (100%) for that individual. Once the overall family out-of-pocket maximum is met, the plan will start to pay claims at one hundred percent (100%) for the entire family even if some family members had not met his/her own individual out-of-pocket maximum.

(4) The following services will be paid as a network benefit when provided by a non-network provider:

(A) Emergency services and urgent care;

(B) Covered services that are not available through a network provider within one hundred (100) miles of the member's home. The member must contact the claims administrator before the date of service in order to have a closer non-network provider's claims approved as a network benefit. Such approval is for three (3) months. After three (3) months, the member must contact the claims administrator to reassess network availability; and

(C) Covered services when such services are provided in a network hospital or ambulatory surgical center and are an adjunct to a service being performed by a network provider. Examples of such adjunct services include, but are not limited to, anesthesiology, assistant surgeon, pathology, or radiology.

(5) The following services are not subject to deductible, coinsurance, or copayment requirements and will be paid at one hundred percent (100%) when provided by a network provider:

(A) Preventive care;

(B) Nutrition counseling;

(C) A newborn's initial hospitalization until discharge or transfer to another facility if the mother is a Missouri Consolidated Health

Care Plan (MCHCP) member at the time of birth; and

(D) Four (4) Diabetes Self-Management Education/Training visits with a certified diabetes educator when ordered by a provider.

(6) Influenza vaccinations provided by a non-network provider will be reimbursed up to twenty-five dollars (\$25) once the member submits a receipt and a reimbursement form to the claims administrator.

(7) Married, active employees who are MCHCP subscribers and have enrolled children may meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must provide the other spouse's Social Security number (SSN) and report the other spouse as eligible for coverage when newly hired and during the open enrollment process. In the medical plan vendor and pharmacy benefit manager systems, the spouse with children enrolled will be considered the subscriber and the spouse that does not have children enrolled will be considered a dependent. If both spouses have children enrolled, the spouse with the higher Social Security number (SSN) will be considered the subscriber. Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

(8) Each subscriber will have access to payment information of the family unit only when authorization is granted by the adult covered dependent(s).

(9) Expenses toward the deductible and out-of-pocket maximum will be transferred if the member changes non-Medicare medical plans or continues enrollment under another subscriber's non-Medicare medical plan within the same plan year.

(10) Copayments. Copayments apply to network services unless otherwise specified.

(A) Office visit—primary care: twenty-five dollars (\$25); mental health: twenty-five dollars (\$25); specialist: forty dollars (\$40); chiropractor office visit and/or manipulation: the lesser of twenty dollars (\$20) or fifty percent (50%) of the total cost of services; urgent care: fifty dollars (\$50) network and non-network. All lab, X-ray, or other medical services associated with the office visit apply to the deductible and coinsurance.

(B) Emergency room—two hundred fifty dollars (\$250) network and non-network. Deductible and coinsurance requirements apply to emergency room services in addition to the copayment. If a member is admitted to the hospital or the claims administrator considers the claim to be for a true emergency, the copayment is waived.

(C) Inpatient hospitalization—two hundred dollars (\$200) per admission for network and non-network. Deductible and coinsurance requirements apply to inpatient hospitalization services in addition to the copayment.

(11) Maximum plan payment—non-network medical claims that are not otherwise subject to a contractual discount arrangement are allowed at one hundred ten percent (110%) of Medicare reimbursement. Members may be held liable for the amount of the fee above the allowed amount.

(12) Any claim must be initially submitted within twelve (12) months following the date of service. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

(13) For a member who is an inpatient on the last calendar day of a plan year and remains an inpatient into the next plan year, the prior plan year's applicable copayment, deductible, and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

(14) Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-2.055. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as a non-network benefit. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

(15) Medicare.

(A) When MCHCP becomes aware that the member is eligible for Medicare benefits claims will be processed reflecting Medicare coverage.

(B) If a member does not enroll in Medicare when s/he is eligible and Medicare should be the member's primary plan, the member will be responsible for paying the portion Medicare would have paid. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

(C) If a Medicare primary member chooses a provider who has opted out of Medicare, the member will be responsible for paying the portion Medicare would have paid if the service was performed by a Medicare provider. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed rule covering this same material is published in this issue of the Missouri Register.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 3—Public Entity Membership

EMERGENCY RESCISSION

22 CSR 10-3.060 PPO 600 Plan, PPO 1000 Plan, and Health Savings Account Plan Limitations. This rule established the limitations and exclusions of the Missouri Consolidated Health Care Plan PPO 600 Plan, PPO 1000 Plan, and Health Savings Account Plan.

PURPOSE: This rule is being rescinded because the PPO 600 and PPO 1000 Plans will not be offered after December 31, 2018.

EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency rescission is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability

of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be filed as an emergency rescission to maintain the integrity of the current health care plan. This emergency rescission fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one method of protecting the MCHCP trust fund from more costly expenses. This emergency rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the **Missouri Register**. This emergency rescission complies with the protections extended by the **Missouri and United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rescission was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the **Code of State Regulations**. Emergency rescission filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed rescission covering this same material is published in this issue of the **Missouri Register**.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

EMERGENCY RULE

22 CSR 10-3.061 Plan Limitations

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 750 Plan, PPO 1250 Plan, and Health Savings Account (HSA) Plan limitations of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency rule is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule to maintain the integrity of the current health care plan. This emergency rule fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting

the MCHCP trust fund from more costly expenses. This emergency rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the **Missouri Register**. This emergency rule complies with the protections extended by the **Missouri and United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.

(1) Benefits shall not be payable for, or in connection with, any medical benefits, services, or supplies which do not come within the definition of covered charges. In addition, the items specified in this rule are not covered unless expressly stated otherwise and then only to the extent expressly provided herein or in 22 CSR 10-3.057 or 22 CSR 10-3.090.

(A) Abortion—unless the life of the mother is endangered if the fetus is carried to term or due to death of the fetus.

(B) Acts of war including—injury or illness caused, or contributed to, by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.

(C) Alternative therapies—that are outside conventional medicine including, but not limited to, acupuncture, acupressure, homeopathy, hypnosis, massage therapy, reflexology, and biofeedback.

(D) Assistive listening device.

(E) Assistant surgeon services—unless determined to meet the clinical eligibility for coverage under the plan.

(F) Athletic enhancement services and sports performance training.

(G) Autopsy.

(H) Birthing center.

(I) Blood donor expenses.

(J) Blood pressure cuffs/monitors.

(K) Care received without charge.

(L) Charges exceeding the vendor contracted rate or benefit limit.

(M) Charges resulting from the failure to appropriately cancel a scheduled appointment.

(N) Childbirth classes.

(O) Comfort and convenience items.

(P) Cosmetic procedures.

(Q) Custodial or domiciliary care—including services and supplies that assist members in the activities of daily living such as walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet; preparation of special diets; supervision of medication that is usually self-administered; or other services that can be performed by persons who are not providers.

(R) Dental care, including oral surgery.

(S) Devices or supplies bundled as part of a service are not separately covered.

(T) Dialysis received through a non-network provider.

(U) Educational or psychological testing unless part of a treatment program for covered services.

(V) Examinations requested by a third party.

(W) Exercise equipment.

(X) Experimental/investigational/unproven services, procedures, supplies, or drugs as determined by the claims administrator.

(Y) Eye services and associated expenses for orthoptics, eye exercises, radial keratotomy, LASIK, and other refractive eye surgery.

(Z) Genetic testing based on family history alone, except for breast cancer susceptibility gene (BRCA) testing.

(AA) Health and athletic club membership—including costs of enrollment.

(BB) Hearing aid replacement batteries.

(CC) Home births.

(DD) Infertility treatment beyond the covered services to diagnose the condition.

(EE) Infusions received through a non-network provider.

(FF) Level of care, greater than is needed for the treatment of the illness or injury.

(GG) Long-term care.

(HH) Maxillofacial surgery.

(II) Medical care and supplies to the extent that they are payable under—

1. A plan or program operated by a national government or one (1) of its agencies; or

2. Any state's cash sickness or similar law, including any group insurance policy approved under such law.

(JJ) Medical service performed by a family member—including a person who ordinarily resides in the subscriber's household or is related to the member, such as a spouse, parent, child, sibling, or brother/sister-in-law.

(KK) Military service-connected injury or illness—including expenses relating to Veterans Affairs or a military hospital.

(LL) Never events—never events on a list compiled by the National Quality Forum of inexcusable outcomes in a health care setting.

(MM) Nocturnal enuresis alarm.

(NN) Drugs that the pharmacy benefit manager (PBM) has excluded from the formulary and will not cover as a non-formulary drug unless it is approved in advance by the PBM.

(OO) Non-medically necessary services.

(PP) Non-provider allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning.

(QQ) Non-reusable disposable supplies.

(RR) Online weight management programs.

(SS) Other charges as follows:

1. Charges that would not otherwise be incurred if the subscriber was not covered by the plan;

2. Charges for which the subscriber or his/her dependents are not legally obligated to pay including, but not limited to, any portion of any charges that are discounted;

3. Charges made in the subscriber's name but which are actually due to the injury or illness of a different person not covered by the plan; and

4. No coverage for miscellaneous service charges including, but not limited to, charges for telephone consultations, administrative fees such as filling out paperwork or copy charges, or late payments.

(TT) Over-the-counter medications with or without a prescription including, but not limited to, analgesics, antipyretics, non-sedating antihistamines, unless otherwise covered as a preventive service.

(UU) Physical and recreational fitness.

(VV) Private-duty nursing.

(WW) Routine foot care without the presence of systemic disease that affects lower extremities.

(XX) Services obtained at a government facility if care is provided without charge.

(YY) Sex therapy.

(ZZ) Surrogacy—pregnancy coverage is limited to plan member.

(AAA) Telehealth site origination fees or costs for the provision of telehealth services are not covered.

(BBB) Therapy. Physical, occupational, and speech therapy are not covered for the following:

1. Physical therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Physical therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

E. Work hardening programs;

F. Back school;

G. Vocational rehabilitation programs and any program with the primary goal of returning an individual to work;

H. Group physical therapy (because it is not one-on-one, individualized to the specific person's needs); or

I. Services for the purpose of enhancing athletic or sports performance;

2. Occupational therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Occupational therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., physical therapy);

E. Work hardening programs;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Group occupational therapy (because it is not one-on-one, individualized to the specific person's needs); and

H. Driving safety/driver training; and

3. Speech or voice therapy—

A. Any computer-based learning program for speech or voice training purposes;

B. School speech programs;

C. Speech or voice therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

D. Group speech or voice therapy (because it is not one-on-one, individualized to the specific person's needs);

E. Maintenance programs of routine, repetitive drills/exercises that do not require the skills of a speech-language therapist and that can be reinforced by the individual or caregiver;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Therapy or treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

H. Therapy or treatment provided to improve or enhance job, school, or recreational performance; and

I. Long-term rehabilitative services when significant therapeutic improvement is not expected.

(CCC) Travel expenses.

(DDD) Vaccinations requested by third party.

(EEE) Workers' Compensation services or supplies for an illness or injury eligible for, or covered by, any federal, state, or local government Workers' Compensation Act, occupational disease law, or other similar legislation.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. A proposed rule covering this same material is published in this issue of the Missouri Register.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 3—Public Entity Membership

EMERGENCY AMENDMENT

22 CSR 10-3.080 Miscellaneous Provisions. The Missouri Consolidated Health Care Plan is amending section (5).

PURPOSE: This amendment revises the names of the medical plans.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity

employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.

(5) The PPO [600] 750 Plan, PPO [1000] 1250 Plan, and Health Savings Account Plan benefits including pharmacy are self-funded by the plan. MCHCP has subrogation rights under section 376.433, RSMo for any amounts expended for these benefits.

AUTHORITY: section 103.059, RSMo [2000] 2016. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. Amended: Filed Oct. 30, 2012, effective May 30, 2013. Amended: Filed Oct. 29, 2014, effective May 30, 2015. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

EMERGENCY AMENDMENT

22 CSR 10-3.090 Pharmacy Benefit Summary. The Missouri Consolidated Health Care Plan is amending the purpose and section (1).

PURPOSE: This amendment revises the names of the medical plans, copayments, preventive drugs, and out-of-pocket maximum.

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Pharmacy Benefit Summary for the [PPO 600 Plan, PPO 1000 Plan] **PPO 750 Plan, PPO 1250 Plan, Health Savings Account (HSA) Plan** of the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2019, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (public entity employee members, retirees, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability

of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to public entity employee members, retirees, and their families as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 31, 2018, becomes effective January 1, 2019, and expires June 29, 2019.

(1) The pharmacy benefit provides coverage for prescription drugs. Vitamin and nutrient coverage is limited to prenatal agents, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents as prescribed by a provider.

(A) **PPO [600] 750 Plan** and **PPO [1000] 1250 Plan** Prescription Drug Coverage.

1. Network.

A. Preferred formulary generic drug copayment: [*Eight dollars (\$8)*] **Ten Dollars (\$10)** for up to a thirty-one- (31-) day supply; [*sixteen dollars (\$16)*] **twenty dollars (\$20)** for up to a sixty- (60-) day supply; and [*twenty-four dollars (\$24)*] **thirty dollars (\$30)** for up to a ninety- (90-) day supply for a generic drug on the formulary; formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%).

B. Preferred formulary brand drug copayment: [*Thirty-five dollars (\$35)*] **Forty dollars (\$40)** for up to a thirty-one- (31-) day supply; [*seventy dollars (\$70)*] **eighty dollars (\$80)** for up to a sixty- (60-) day supply; and [*one hundred and five dollars (\$105)*] **one hundred twenty dollars (\$120)** for up to a ninety- (90-) day supply for a brand drug on the formulary; formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%).

C. Non-preferred formulary drug and approved excluded drug copayment: One hundred dollars (\$100) for up to a thirty-one- (31-) day supply; two hundred dollars (\$200) for up to a sixty- (60-) day supply; and three hundred dollars (\$300) for up to a ninety- (90-) day supply for a drug not on the formulary.

D. Specialty drug (as designated as such by the PBM) copayment: Seventy-five dollars (\$75) for up to a thirty-one- (31-) day supply for a specialty drug on the formulary;

[*D./E.* Diabetic drug (as designated as such by the PBM) copayment: [*f*]/Fifty percent (50%) of the applicable network copayment.

[*E./F.* Home delivery programs.

(I) Maintenance prescriptions may be filled through the pharmacy benefit manager's (PBM's) home delivery program. A member must choose how maintenance prescription(s) will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

(a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2)

orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision and the amount charged will not apply to the out-of-pocket maximum.

(b) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM.

(II) Specialty drugs are covered only through the specialty home delivery network for up to a thirty-one- (31-) day supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. All specialty prescriptions must be filled through the PBM's specialty pharmacy, unless the prescription is identified by the PBM as emergent. The first fill of a specialty prescription may be filled through a retail pharmacy.

(a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply with a prorated copayment. If the member is able to continue with the medication, the remaining supply will be shipped with the remaining portion of the copayment. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment.

(III) Prescriptions filled through home delivery programs have the following copayments:

(a) Preferred formulary generic drug copayments: *[Eight dollars (\$8)] Ten dollars (\$10)* for up to a thirty-one- (31-) day supply; *[sixteen dollars (\$16)] twenty dollars (\$20)* for up to a sixty- (60-) day supply; and twenty dollars (\$20) for up to a ninety- (90-) day supply for a generic drug on the formulary;

(b) Preferred formulary brand drug copayments: *[Thirty-five dollars (\$35)] Forty dollars (\$40)* for up to a thirty-one- (31-) day supply; *[seventy dollars (\$70)] eighty dollars (\$80)* for up to a sixty- (60-) day supply; and *[eighty-seven dollars and fifty cents (\$87.50)] one hundred dollars (\$100)* for up to a ninety- (90-) day supply for a brand drug on the formulary;

(c) Non-preferred formulary drug and approved excluded drug copayments: One hundred dollars (\$100) for up to a thirty-one- (31-) day supply; two hundred dollars (\$200) for up to a sixty- (60-) day supply; and two hundred fifty dollars (\$250) for up to a ninety- (90-) day supply for a drug not on the formulary.

(d) Specialty drug (as designated as such by the PBM) copayment: *Seventy-five dollars (\$75) for up to a thirty-one- (31-) day supply for a specialty drug on the formulary;*

*[F./G. Diabetic drug (as designated as such by the PBM) copayment: *[f/Fifty percent (50%) of the applicable network copayment.**

[G./H. Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount.

[H./I. The copayment for a compound drug is based on the primary drug in the compound. The primary drug in a compound is the most expensive prescription drug in the mix. If any ingredient in the compound is excluded by the plan, the compound will be denied.

[I./J. If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug.

[J./K. If the physician allows for generic substitution and the member chooses a brand-name drug, the member is responsible for the generic copayment and the cost difference between the brand-name and generic drug which shall not apply to the out-of-pocket maximum.

L. Preferred select brand drugs, as determined by the PBM: Ten dollars (\$10) for up to a thirty-one- (31-) day supply; twenty dollars (\$20) for up to a sixty- (60-) day supply; and twenty-five dollars (\$25) for up to a ninety- (90-) day supply;

[K./M. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and

Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy. The following are also covered at one hundred percent (100%) when filled at a network pharmacy:

[(I)] Prescribed Vitamin D for all ages;

(a) The range for preventive Vitamin D at or below 1000 IU of Vitamin D₂ or D₃ per dose;

[(II)] Zoster (shingles) vaccine and administration for members age fifty (50) years and older;

[(III)](I) [Influenza v]accine [and administration as] recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

[(IV)](II) Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer;

[(V)](III) Prescribed preferred diabetic test strips and lancets; and

[(VI)](IV) One (1) preferred glucometer.

2. Non-network: If a member chooses to use a non-network pharmacy for non-specialty prescriptions, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable network copayment.

3. Out-of-pocket maximum.

A. Network and non-network out-of-pocket maximums are separate.

B. The family out-of-pocket maximum is an aggregate of applicable charges received by all covered family members of the plan. Any combination of covered family member applicable charges may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.

[C. PPO 600 Individual—five thousand one hundred dollars (\$5,100).

D. PPO 600 Family—ten thousand two hundred dollars (\$10,200).

E. PPO 1000 Individual—two thousand one hundred dollars (\$2,100).

F. PPO 1000 Family—four thousand two hundred dollars (\$4,200).]

C. Network individual—four thousand one hundred fifty dollars (\$4,150).

D. Network family—eight thousand three hundred dollars (\$8,300).

E. Non-network—no maximum.

(B) Health Savings Account (HSA) Plan Prescription Drug Coverage. Medical and pharmacy expenses are combined to apply toward the appropriate network or non-network deductible and out-of-pocket maximum specified in 22 CSR 10-3.055.

1. Network.

A. Preferred formulary generic drug: Ten percent (10%) coinsurance after deductible for a generic drug on the formulary.

B. Preferred formulary brand drug: Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary.

C. Non-preferred formulary drug and approved excluded drug: Forty percent (40%) coinsurance after deductible for a drug not on the formulary.

D. Diabetic drug (as designated by the PBM) coinsurance: *[f/Fifty percent (50%) of the applicable network coinsurance after deductible has been met.*

E. Home delivery program.

(I) Maintenance prescriptions may be filled through the PBM's home delivery program. A member must choose how maintenance prescriptions will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

(a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2)

orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision.

(b) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM.

(II) Specialty drugs are covered only through network home delivery for up to a thirty-one- (31-) day supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. All specialty prescriptions must be filled through the PBM's specialty pharmacy, unless the prescription is identified by the PBM as emergent. The first fill of a specialty prescription identified to be emergent, may be filled through a retail pharmacy.

(a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply. If the member is able to continue with the medication, the remaining supply will be shipped. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment.

F. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy. The following are also covered at one hundred percent (100%) when filled at a network pharmacy:

[(I)] *Prescribed Vitamin D for all ages.*

(a) *The range for preventive Vitamin D is at or below 1000 IU of Vitamin D₂ or D₃ per dose;*

[(II)] *Zoster (shingles) vaccine and administration for members age fifty (50) years and older;*

[(III)](I) *Influenza v/Vaccines and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and*

[(IV)](II) *Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer;*

G. The following are covered at one hundred percent (100%) after deductible is met and when filled at a network pharmacy:

(I) *Prescribed preferred diabetic test strips and lancets; and*

(II) *One (1) preferred glucometer.*

H. If any ingredient in a compound drug is excluded by the plan, the compound will be denied.

2. Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable deductible or coinsurance.

A. Preferred formulary generic drug: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a generic drug on the formulary.

B. Preferred formulary brand drug: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a brand drug on the formulary.

C. Non-preferred formulary drug and approved excluded drug: Fifty percent (50%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a drug not on the formulary.

D. Diabetic drug (as designated by the PBM) coinsurance: ~~f/f~~Fifty percent (50%) of the applicable non-network coinsurance after deductible has been met.

29, 2019. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June

The Secretary of State shall publish all executive orders beginning January 1, 2003, pursuant to section 536.035.2, RSMo 2016.



State of Missouri

Governor's Proclamation

WHEREAS, Article IV, Section 27, authorizes the Governor to control the rate at which any appropriation is expended by allotment and, further, authorizes the Governor to reduce the expenditures of the state or any of its agencies below their appropriations whenever the actual revenues are less than the revenue estimates upon which the appropriations were based; and

WHEREAS, in addition to the power to control the rate of expenditure established in Article IV, Section 27, three percent of each appropriation, with the exception of amounts for personal service to pay salaries fixed by law, shall be set aside pursuant to section 33.290, RSMo, as a reserve fund and not subject to expenditure except with the approval of the Governor; and

WHEREAS, Article IV, Section 27.2, provides that the Governor notify the General Assembly "whenever the rate at which any appropriation shall be expended is not equal quarterly allotments, the sum of which shall be equal to the amount of the appropriation"; and

WHEREAS, due to a variety of factors, including the three percent reserve that is legally required by section 33.290, RSMo, the rate at which most appropriations are expended is not in "equal quarterly allotments, the sum of which shall be equal to the amount of the appropriation"; and

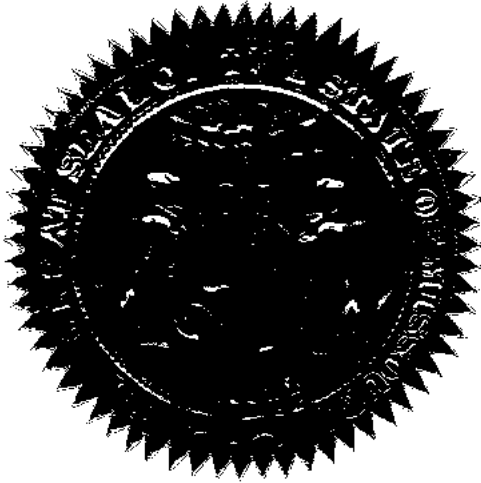
WHEREAS, Article IV, Section 27.3, provides that the Governor notify the General Assembly "when the governor reduces one or more items or portions of items of appropriation of money as a result of actual revenues being less than the revenue estimates upon which the appropriations were based."

NOW THEREFORE, I, Michael L. Parson, GOVERNOR OF THE STATE OF MISSOURI, pursuant to Article IV, Section 27, do hereby make the following notification to the Ninety-Ninth General Assembly of the State of Missouri:

I hereby notify the General Assembly, pursuant to Article IV, Section 27.2 of the Missouri Constitution, that through the first quarter of fiscal year 2019, the rate of expenditure for each of the appropriation lines in the fiscal year 2019 budget attached as Exhibit A is not in equal quarterly allotments, the sum of which shall be equal to the amount of the appropriation.

I further notify the General Assembly, pursuant to Article IV, Section 27.3 of the Missouri Constitution, that I have taken no action to permanently reduce one or more items or portions of items of appropriation of money as a result of actual revenues being less than the revenue estimates upon which the appropriations were based in the fiscal year 2019 budget.

IN TESTIMONY WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, this 31st day of October 2018.



A handwritten signature in black ink, reading "Michael L. Parson", written over a horizontal line.

Michael L. Parson
GOVERNOR

ATTEST:

A handwritten signature in black ink, reading "Jay Ashcroft", written over a horizontal line.

SECRETARY OF STATE

Exhibit A

#	Agency	Budget Appropriation Line
1	OFFICE ADMINISTRATION-OPER	01.010
2	OFFICE ADMINISTRATION-OPER	01.015
3	OFFICE ADMINISTRATION-OPER	01.015
4	OFFICE ADMINISTRATION-OPER	01.020
5	OFFICE ADMINISTRATION-OPER	01.020
6	OFFICE ADMINISTRATION-OPER	01.025
7	OFFICE ADMINISTRATION-OPER	01.025
8	OFFICE ADMINISTRATION-OPER	01.025
9	OFFICE ADMINISTRATION-OPER	01.030
10	OFFICE ADMINISTRATION-OPER	01.035
11	ELEM & SEC EDUCATION-OPER	02.005
12	ELEM & SEC EDUCATION-OPER	02.005
13	ELEM & SEC EDUCATION-OPER	02.005
14	ELEM & SEC EDUCATION-OPER	02.005
15	ELEM & SEC EDUCATION-OPER	02.010
16	ELEM & SEC EDUCATION-OPER	02.010
17	ELEM & SEC EDUCATION-OPER	02.015
18	ELEM & SEC EDUCATION-OPER	02.015
19	ELEM & SEC EDUCATION-OPER	02.015
20	ELEM & SEC EDUCATION-OPER	02.015
21	ELEM & SEC EDUCATION-OPER	02.015
22	ELEM & SEC EDUCATION-OPER	02.015
23	ELEM & SEC EDUCATION-OPER	02.015
24	ELEM & SEC EDUCATION-OPER	02.015
25	ELEM & SEC EDUCATION-OPER	02.015
26	ELEM & SEC EDUCATION-OPER	02.015
27	ELEM & SEC EDUCATION-OPER	02.015
28	ELEM & SEC EDUCATION-OPER	02.015
29	ELEM & SEC EDUCATION-OPER	02.015
30	ELEM & SEC EDUCATION-OPER	02.015
31	ELEM & SEC EDUCATION-OPER	02.015
32	ELEM & SEC EDUCATION-OPER	02.015
33	ELEM & SEC EDUCATION-OPER	02.015
34	ELEM & SEC EDUCATION-OPER	02.020
35	ELEM & SEC EDUCATION-OPER	02.025
36	ELEM & SEC EDUCATION-OPER	02.026
37	ELEM & SEC EDUCATION-OPER	02.027
38	ELEM & SEC EDUCATION-OPER	02.028
39	ELEM & SEC EDUCATION-OPER	02.030
40	ELEM & SEC EDUCATION-OPER	02.031
41	ELEM & SEC EDUCATION-OPER	02.032
42	ELEM & SEC EDUCATION-OPER	02.033
43	ELEM & SEC EDUCATION-OPER	02.034
44	ELEM & SEC EDUCATION-OPER	02.035
45	ELEM & SEC EDUCATION-OPER	02.040
46	ELEM & SEC EDUCATION-OPER	02.045
47	ELEM & SEC EDUCATION-OPER	02.045
48	ELEM & SEC EDUCATION-OPER	02.045
49	ELEM & SEC EDUCATION-OPER	02.050
50	ELEM & SEC EDUCATION-OPER	02.055
51	ELEM & SEC EDUCATION-OPER	02.060
52	ELEM & SEC EDUCATION-OPER	02.060
53	ELEM & SEC EDUCATION-OPER	02.060
54	ELEM & SEC EDUCATION-OPER	02.060
55	ELEM & SEC EDUCATION-OPER	02.060
56	ELEM & SEC EDUCATION-OPER	02.060
57	ELEM & SEC EDUCATION-OPER	02.060
58	ELEM & SEC EDUCATION-OPER	02.060

Exhibit A

#	Agency	Budget Appropriation Line
59	ELEM & SEC EDUCATION-OPER	02.060
60	ELEM & SEC EDUCATION-OPER	02.065
61	ELEM & SEC EDUCATION-OPER	02.065
62	ELEM & SEC EDUCATION-OPER	02.065
63	ELEM & SEC EDUCATION-OPER	02.065
64	ELEM & SEC EDUCATION-OPER	02.065
65	ELEM & SEC EDUCATION-OPER	02.070
66	ELEM & SEC EDUCATION-OPER	02.075
67	ELEM & SEC EDUCATION-OPER	02.080
68	ELEM & SEC EDUCATION-OPER	02.080
69	ELEM & SEC EDUCATION-OPER	02.080
70	ELEM & SEC EDUCATION-OPER	02.085
71	ELEM & SEC EDUCATION-OPER	02.090
72	ELEM & SEC EDUCATION-OPER	02.095
73	ELEM & SEC EDUCATION-OPER	02.100
74	ELEM & SEC EDUCATION-OPER	02.105
75	ELEM & SEC EDUCATION-OPER	02.110
76	ELEM & SEC EDUCATION-OPER	02.115
77	ELEM & SEC EDUCATION-OPER	02.120
78	ELEM & SEC EDUCATION-OPER	02.125
79	ELEM & SEC EDUCATION-OPER	02.130
80	ELEM & SEC EDUCATION-OPER	02.135
81	ELEM & SEC EDUCATION-OPER	02.140
82	ELEM & SEC EDUCATION-OPER	02.145
83	ELEM & SEC EDUCATION-OPER	02.150
84	ELEM & SEC EDUCATION-OPER	02.150
85	ELEM & SEC EDUCATION-OPER	02.150
86	ELEM & SEC EDUCATION-OPER	02.155
87	ELEM & SEC EDUCATION-OPER	02.160
88	ELEM & SEC EDUCATION-OPER	02.160
89	ELEM & SEC EDUCATION-OPER	02.160
90	ELEM & SEC EDUCATION-OPER	02.160
91	ELEM & SEC EDUCATION-OPER	02.160
92	ELEM & SEC EDUCATION-OPER	02.165
93	ELEM & SEC EDUCATION-OPER	02.165
94	ELEM & SEC EDUCATION-OPER	02.170
95	ELEM & SEC EDUCATION-OPER	02.175
96	ELEM & SEC EDUCATION-OPER	02.180
97	ELEM & SEC EDUCATION-OPER	02.180
98	ELEM & SEC EDUCATION-OPER	02.180
99	ELEM & SEC EDUCATION-OPER	02.180
100	ELEM & SEC EDUCATION-OPER	02.180
101	ELEM & SEC EDUCATION-OPER	02.185
102	ELEM & SEC EDUCATION-OPER	02.185
103	ELEM & SEC EDUCATION-OPER	02.185
104	ELEM & SEC EDUCATION-OPER	02.190
105	ELEM & SEC EDUCATION-OPER	02.195
106	ELEM & SEC EDUCATION-OPER	02.200
107	ELEM & SEC EDUCATION-OPER	02.205
108	ELEM & SEC EDUCATION-OPER	02.210
109	ELEM & SEC EDUCATION-OPER	02.215
110	ELEM & SEC EDUCATION-OPER	02.220
111	ELEM & SEC EDUCATION-OPER	02.225
112	ELEM & SEC EDUCATION-OPER	02.225
113	ELEM & SEC EDUCATION-OPER	02.225
114	ELEM & SEC EDUCATION-OPER	02.225
115	ELEM & SEC EDUCATION-OPER	02.225
116	ELEM & SEC EDUCATION-OPER	02.230

Exhibit A

#	Agency	Budget Appropriation Line
117	ELEM & SEC EDUCATION-OPER	02.230
118	ELEM & SEC EDUCATION-OPER	02.230
119	ELEM & SEC EDUCATION-OPER	02.230
120	ELEM & SEC EDUCATION-OPER	02.230
121	ELEM & SEC EDUCATION-OPER	02.230
122	ELEM & SEC EDUCATION-OPER	02.235
123	ELEM & SEC EDUCATION-OPER	02.235
124	ELEM & SEC EDUCATION-OPER	02.235
125	ELEM & SEC EDUCATION-OPER	02.235
126	ELEM & SEC EDUCATION-OPER	02.235
127	ELEM & SEC EDUCATION-OPER	02.235
128	ELEM & SEC EDUCATION-OPER	02.235
129	ELEM & SEC EDUCATION-OPER	02.235
130	ELEM & SEC EDUCATION-OPER	02.240
131	ELEM & SEC EDUCATION-OPER	02.245
132	ELEM & SEC EDUCATION-OPER	02.250
133	ELEM & SEC EDUCATION-OPER	02.255
134	ELEM & SEC EDUCATION-OPER	02.260
135	ELEM & SEC EDUCATION-OPER	02.265
136	ELEM & SEC EDUCATION-OPER	02.270
137	ELEM & SEC EDUCATION-OPER	02.275
138	ELEM & SEC EDUCATION-OPER	02.280
139	ELEM & SEC EDUCATION-OPER	02.285
140	HIGHER EDUCATION-OPERATING	03.005
141	HIGHER EDUCATION-OPERATING	03.005
142	HIGHER EDUCATION-OPERATING	03.005
143	HIGHER EDUCATION-OPERATING	03.005
144	HIGHER EDUCATION-OPERATING	03.005
145	HIGHER EDUCATION-OPERATING	03.005
146	HIGHER EDUCATION-OPERATING	03.005
147	HIGHER EDUCATION-OPERATING	03.005
148	HIGHER EDUCATION-OPERATING	03.005
149	HIGHER EDUCATION-OPERATING	03.010
150	HIGHER EDUCATION-OPERATING	03.010
151	HIGHER EDUCATION-OPERATING	03.015
152	HIGHER EDUCATION-OPERATING	03.020
153	HIGHER EDUCATION-OPERATING	03.025
154	HIGHER EDUCATION-OPERATING	03.025
155	HIGHER EDUCATION-OPERATING	03.025
156	HIGHER EDUCATION-OPERATING	03.030
157	HIGHER EDUCATION-OPERATING	03.030
158	HIGHER EDUCATION-OPERATING	03.035
159	HIGHER EDUCATION-OPERATING	03.035
160	HIGHER EDUCATION-OPERATING	03.040
161	HIGHER EDUCATION-OPERATING	03.041
162	HIGHER EDUCATION-OPERATING	03.045
163	HIGHER EDUCATION-OPERATING	03.045
164	HIGHER EDUCATION-OPERATING	03.045
165	HIGHER EDUCATION-OPERATING	03.050
166	HIGHER EDUCATION-OPERATING	03.055
167	HIGHER EDUCATION-OPERATING	03.055
168	HIGHER EDUCATION-OPERATING	03.055
169	HIGHER EDUCATION-OPERATING	03.055
170	HIGHER EDUCATION-OPERATING	03.055
171	HIGHER EDUCATION-OPERATING	03.055
172	HIGHER EDUCATION-OPERATING	03.060
173	HIGHER EDUCATION-OPERATING	03.065
174	HIGHER EDUCATION-OPERATING	03.065

Exhibit A

#	Agency	Budget Appropriation Line
175	HIGHER EDUCATION-OPERATING	03.065
176	HIGHER EDUCATION-OPERATING	03.070
177	HIGHER EDUCATION-OPERATING	03.075
178	HIGHER EDUCATION-OPERATING	03.080
179	HIGHER EDUCATION-OPERATING	03.080
180	HIGHER EDUCATION-OPERATING	03.080
181	HIGHER EDUCATION-OPERATING	03.080
182	HIGHER EDUCATION-OPERATING	03.085
183	HIGHER EDUCATION-OPERATING	03.090
184	HIGHER EDUCATION-OPERATING	03.095
185	HIGHER EDUCATION-OPERATING	03.100
186	HIGHER EDUCATION-OPERATING	03.100
187	HIGHER EDUCATION-OPERATING	03.100
188	HIGHER EDUCATION-OPERATING	03.100
189	HIGHER EDUCATION-OPERATING	03.100
190	HIGHER EDUCATION-OPERATING	03.105
191	HIGHER EDUCATION-OPERATING	03.110
192	HIGHER EDUCATION-OPERATING	03.115
193	HIGHER EDUCATION-OPERATING	03.120
194	HIGHER EDUCATION-OPERATING	03.121
195	HIGHER EDUCATION-OPERATING	03.127
196	HIGHER EDUCATION-OPERATING	03.200
197	HIGHER EDUCATION-OPERATING	03.200
198	HIGHER EDUCATION-OPERATING	03.200
199	HIGHER EDUCATION-OPERATING	03.200
200	HIGHER EDUCATION-OPERATING	03.200
201	HIGHER EDUCATION-OPERATING	03.200
202	HIGHER EDUCATION-OPERATING	03.200
203	HIGHER EDUCATION-OPERATING	03.200
204	HIGHER EDUCATION-OPERATING	03.200
205	HIGHER EDUCATION-OPERATING	03.200
206	HIGHER EDUCATION-OPERATING	03.200
207	HIGHER EDUCATION-OPERATING	03.200
208	HIGHER EDUCATION-OPERATING	03.200
209	HIGHER EDUCATION-OPERATING	03.200
210	HIGHER EDUCATION-OPERATING	03.200
211	HIGHER EDUCATION-OPERATING	03.200
212	HIGHER EDUCATION-OPERATING	03.200
213	HIGHER EDUCATION-OPERATING	03.200
214	HIGHER EDUCATION-OPERATING	03.200
215	HIGHER EDUCATION-OPERATING	03.200
216	HIGHER EDUCATION-OPERATING	03.200
217	HIGHER EDUCATION-OPERATING	03.200
218	HIGHER EDUCATION-OPERATING	03.200
219	HIGHER EDUCATION-OPERATING	03.200
220	HIGHER EDUCATION-OPERATING	03.200
221	HIGHER EDUCATION-OPERATING	03.200
222	HIGHER EDUCATION-OPERATING	03.200
223	HIGHER EDUCATION-OPERATING	03.200
224	HIGHER EDUCATION-OPERATING	03.200
225	HIGHER EDUCATION-OPERATING	03.200
226	HIGHER EDUCATION-OPERATING	03.200
227	HIGHER EDUCATION-OPERATING	03.200
228	HIGHER EDUCATION-OPERATING	03.200
229	HIGHER EDUCATION-OPERATING	03.200
230	HIGHER EDUCATION-OPERATING	03.200
231	HIGHER EDUCATION-OPERATING	03.200
232	HIGHER EDUCATION-OPERATING	03.200

Exhibit A

#	Agency	Budget Appropriation Line
233	HIGHER EDUCATION-OPERATING	03.200
234	HIGHER EDUCATION-OPERATING	03.200
235	HIGHER EDUCATION-OPERATING	03.200
236	HIGHER EDUCATION-OPERATING	03.200
237	HIGHER EDUCATION-OPERATING	03.200
238	HIGHER EDUCATION-OPERATING	03.200
239	HIGHER EDUCATION-OPERATING	03.200
240	HIGHER EDUCATION-OPERATING	03.200
241	HIGHER EDUCATION-OPERATING	03.200
242	HIGHER EDUCATION-OPERATING	03.200
243	HIGHER EDUCATION-OPERATING	03.200
244	HIGHER EDUCATION-OPERATING	03.200
245	HIGHER EDUCATION-OPERATING	03.200
246	HIGHER EDUCATION-OPERATING	03.205
247	HIGHER EDUCATION-OPERATING	03.205
248	HIGHER EDUCATION-OPERATING	03.205
249	HIGHER EDUCATION-OPERATING	03.210
250	HIGHER EDUCATION-OPERATING	03.210
251	HIGHER EDUCATION-OPERATING	03.210
252	HIGHER EDUCATION-OPERATING	03.215
253	HIGHER EDUCATION-OPERATING	03.215
254	HIGHER EDUCATION-OPERATING	03.215
255	HIGHER EDUCATION-OPERATING	03.220
256	HIGHER EDUCATION-OPERATING	03.220
257	HIGHER EDUCATION-OPERATING	03.220
258	HIGHER EDUCATION-OPERATING	03.225
259	HIGHER EDUCATION-OPERATING	03.225
260	HIGHER EDUCATION-OPERATING	03.225
261	HIGHER EDUCATION-OPERATING	03.225
262	HIGHER EDUCATION-OPERATING	03.230
263	HIGHER EDUCATION-OPERATING	03.230
264	HIGHER EDUCATION-OPERATING	03.230
265	HIGHER EDUCATION-OPERATING	03.235
266	HIGHER EDUCATION-OPERATING	03.235
267	HIGHER EDUCATION-OPERATING	03.235
268	HIGHER EDUCATION-OPERATING	03.240
269	HIGHER EDUCATION-OPERATING	03.240
270	HIGHER EDUCATION-OPERATING	03.240
271	HIGHER EDUCATION-OPERATING	03.240
272	HIGHER EDUCATION-OPERATING	03.245
273	HIGHER EDUCATION-OPERATING	03.245
274	HIGHER EDUCATION-OPERATING	03.245
275	HIGHER EDUCATION-OPERATING	03.250
276	HIGHER EDUCATION-OPERATING	03.250
277	HIGHER EDUCATION-OPERATING	03.250
278	HIGHER EDUCATION-OPERATING	03.250
279	HIGHER EDUCATION-OPERATING	03.255
280	HIGHER EDUCATION-OPERATING	03.255
281	HIGHER EDUCATION-OPERATING	03.255
282	HIGHER EDUCATION-OPERATING	03.255
283	HIGHER EDUCATION-OPERATING	03.260
284	HIGHER EDUCATION-OPERATING	03.265
285	HIGHER EDUCATION-OPERATING	03.265
286	HIGHER EDUCATION-OPERATING	03.270
287	HIGHER EDUCATION-OPERATING	03.275
288	HIGHER EDUCATION-OPERATING	03.280
289	HIGHER EDUCATION-OPERATING	03.280
290	HIGHER EDUCATION-OPERATING	03.285

Exhibit A

#	Agency	Budget Appropriation Line
291	HIGHER EDUCATION-OPERATING	03.290
292	REVENUE-OPERATING	04.005
293	REVENUE-OPERATING	04.005
294	REVENUE-OPERATING	04.005
295	REVENUE-OPERATING	04.005
296	REVENUE-OPERATING	04.005
297	REVENUE-OPERATING	04.005
298	REVENUE-OPERATING	04.005
299	REVENUE-OPERATING	04.005
300	REVENUE-OPERATING	04.005
301	REVENUE-OPERATING	04.005
302	REVENUE-OPERATING	04.005
303	REVENUE-OPERATING	04.005
304	REVENUE-OPERATING	04.005
305	REVENUE-OPERATING	04.005
306	REVENUE-OPERATING	04.005
307	REVENUE-OPERATING	04.005
308	REVENUE-OPERATING	04.005
309	REVENUE-OPERATING	04.005
310	REVENUE-OPERATING	04.010
311	REVENUE-OPERATING	04.010
312	REVENUE-OPERATING	04.010
313	REVENUE-OPERATING	04.010
314	REVENUE-OPERATING	04.010
315	REVENUE-OPERATING	04.010
316	REVENUE-OPERATING	04.010
317	REVENUE-OPERATING	04.010
318	REVENUE-OPERATING	04.010
319	REVENUE-OPERATING	04.010
320	REVENUE-OPERATING	04.010
321	REVENUE-OPERATING	04.015
322	REVENUE-OPERATING	04.015
323	REVENUE-OPERATING	04.015
324	REVENUE-OPERATING	04.015
325	REVENUE-OPERATING	04.015
326	REVENUE-OPERATING	04.015
327	REVENUE-OPERATING	04.015
328	REVENUE-OPERATING	04.015
329	REVENUE-OPERATING	04.020
330	REVENUE-OPERATING	04.020
331	REVENUE-OPERATING	04.020
332	REVENUE-OPERATING	04.020
333	REVENUE-OPERATING	04.020
334	REVENUE-OPERATING	04.020
335	REVENUE-OPERATING	04.020
336	REVENUE-OPERATING	04.020
337	REVENUE-OPERATING	04.025
338	REVENUE-OPERATING	04.025
339	REVENUE-OPERATING	04.025
340	REVENUE-OPERATING	04.025
341	REVENUE-OPERATING	04.025
342	REVENUE-OPERATING	04.025
343	REVENUE-OPERATING	04.025
344	REVENUE-OPERATING	04.025
345	REVENUE-OPERATING	04.025
346	REVENUE-OPERATING	04.025
347	REVENUE-OPERATING	04.027
348	REVENUE-OPERATING	04.040

Exhibit A

#	Agency	Budget Appropriation Line
349	REVENUE-OPERATING	04.055
350	REVENUE-OPERATING	04.055
351	REVENUE-OPERATING	04.055
352	REVENUE-OPERATING	04.055
353	REVENUE-OPERATING	04.055
354	REVENUE-OPERATING	04.055
355	REVENUE-OPERATING	04.060
356	REVENUE-OPERATING	04.065
357	REVENUE-OPERATING	04.070
358	REVENUE-OPERATING	04.075
359	REVENUE-OPERATING	04.080
360	REVENUE-OPERATING	04.080
361	REVENUE-OPERATING	04.080
362	REVENUE-OPERATING	04.085
363	REVENUE-OPERATING	04.105
364	REVENUE-OPERATING	04.105
365	REVENUE-OPERATING	04.110
366	REVENUE-OPERATING	04.115
367	REVENUE-OPERATING	04.120
368	REVENUE-OPERATING	04.130
369	REVENUE-OPERATING	04.135
370	REVENUE-OPERATING	04.135
371	REVENUE-OPERATING	04.135
372	REVENUE-OPERATING	04.135
373	REVENUE-OPERATING	04.135
374	REVENUE-OPERATING	04.135
375	REVENUE-OPERATING	04.135
376	REVENUE-OPERATING	04.135
377	REVENUE-OPERATING	04.135
378	REVENUE-OPERATING	04.135
379	REVENUE-OPERATING	04.140
380	REVENUE-OPERATING	04.145
381	REVENUE-OPERATING	04.150
382	REVENUE-OPERATING	04.155
383	REVENUE-OPERATING	04.155
384	REVENUE-OPERATING	04.155
385	REVENUE-OPERATING	04.160
386	REVENUE-OPERATING	04.163
387	REVENUE-OPERATING	04.165
388	REVENUE-OPERATING	04.165
389	REVENUE-OPERATING	04.165
390	REVENUE-OPERATING	04.165
391	REVENUE-OPERATING	04.165
392	REVENUE-OPERATING	04.170
393	REVENUE-OPERATING	04.175
394	REVENUE-OPERATING	04.180
395	MO TRANSPORTATION-OPER	04.400
396	MO TRANSPORTATION-OPER	04.400
397	MO TRANSPORTATION-OPER	04.400
398	MO TRANSPORTATION-OPER	04.400
399	MO TRANSPORTATION-OPER	04.400
400	MO TRANSPORTATION-OPER	04.400
401	MO TRANSPORTATION-OPER	04.405
402	MO TRANSPORTATION-OPER	04.405
403	MO TRANSPORTATION-OPER	04.405
404	MO TRANSPORTATION-OPER	04.405
405	MO TRANSPORTATION-OPER	04.405
406	MO TRANSPORTATION-OPER	04.405

Exhibit A

#	Agency	Budget Appropriation Line
407	MO TRANSPORTATION-OPER	04.405
408	MO TRANSPORTATION-OPER	04.405
409	MO TRANSPORTATION-OPER	04.405
410	MO TRANSPORTATION-OPER	04.405
411	MO TRANSPORTATION-OPER	04.405
412	MO TRANSPORTATION-OPER	04.405
413	MO TRANSPORTATION-OPER	04.405
414	MO TRANSPORTATION-OPER	04.405
415	MO TRANSPORTATION-OPER	04.410
416	MO TRANSPORTATION-OPER	04.410
417	MO TRANSPORTATION-OPER	04.410
418	MO TRANSPORTATION-OPER	04.410
419	MO TRANSPORTATION-OPER	04.410
420	MO TRANSPORTATION-OPER	04.415
421	MO TRANSPORTATION-OPER	04.415
422	MO TRANSPORTATION-OPER	04.415
423	MO TRANSPORTATION-OPER	04.415
424	MO TRANSPORTATION-OPER	04.415
425	MO TRANSPORTATION-OPER	04.415
426	MO TRANSPORTATION-OPER	04.415
427	MO TRANSPORTATION-OPER	04.415
428	MO TRANSPORTATION-OPER	04.420
429	MO TRANSPORTATION-OPER	04.420
430	MO TRANSPORTATION-OPER	04.425
431	MO TRANSPORTATION-OPER	04.425
432	MO TRANSPORTATION-OPER	04.430
433	MO TRANSPORTATION-OPER	04.435
434	MO TRANSPORTATION-OPER	04.435
435	MO TRANSPORTATION-OPER	04.435
436	MO TRANSPORTATION-OPER	04.435
437	MO TRANSPORTATION-OPER	04.435
438	MO TRANSPORTATION-OPER	04.435
439	MO TRANSPORTATION-OPER	04.435
440	MO TRANSPORTATION-OPER	04.435
441	MO TRANSPORTATION-OPER	04.435
442	MO TRANSPORTATION-OPER	04.435
443	MO TRANSPORTATION-OPER	04.440
444	MO TRANSPORTATION-OPER	04.440
445	MO TRANSPORTATION-OPER	04.440
446	MO TRANSPORTATION-OPER	04.440
447	MO TRANSPORTATION-OPER	04.445
448	MO TRANSPORTATION-OPER	04.450
449	MO TRANSPORTATION-OPER	04.455
450	MO TRANSPORTATION-OPER	04.460
451	MO TRANSPORTATION-OPER	04.460
452	MO TRANSPORTATION-OPER	04.465
453	MO TRANSPORTATION-OPER	04.470
454	MO TRANSPORTATION-OPER	04.475
455	MO TRANSPORTATION-OPER	04.480
456	MO TRANSPORTATION-OPER	04.485
457	MO TRANSPORTATION-OPER	04.485
458	MO TRANSPORTATION-OPER	04.490
459	MO TRANSPORTATION-OPER	04.495
460	MO TRANSPORTATION-OPER	04.500
461	MO TRANSPORTATION-OPER	04.505
462	MO TRANSPORTATION-OPER	04.505
463	MO TRANSPORTATION-OPER	04.505
464	MO TRANSPORTATION-OPER	04.510

Exhibit A

#	Agency	Budget Appropriation Line
465	MO TRANSPORTATION-OPER	04.515
466	MO TRANSPORTATION-OPER	04.515
467	MO TRANSPORTATION-OPER	04.520
468	MO TRANSPORTATION-OPER	04.525
469	MO TRANSPORTATION-OPER	04.530
470	OFFICE ADMINISTRATION-OPER	05.005
471	OFFICE ADMINISTRATION-OPER	05.005
472	OFFICE ADMINISTRATION-OPER	05.005
473	OFFICE ADMINISTRATION-OPER	05.005
474	OFFICE ADMINISTRATION-OPER	05.005
475	OFFICE ADMINISTRATION-OPER	05.005
476	OFFICE ADMINISTRATION-OPER	05.007
477	OFFICE ADMINISTRATION-OPER	05.010
478	OFFICE ADMINISTRATION-OPER	05.010
479	OFFICE ADMINISTRATION-OPER	05.015
480	OFFICE ADMINISTRATION-OPER	05.015
481	OFFICE ADMINISTRATION-OPER	05.020
482	OFFICE ADMINISTRATION-OPER	05.020
483	OFFICE ADMINISTRATION-OPER	05.020
484	OFFICE ADMINISTRATION-OPER	05.020
485	OFFICE ADMINISTRATION-OPER	05.020
486	OFFICE ADMINISTRATION-OPER	05.020
487	OFFICE ADMINISTRATION-OPER	05.020
488	OFFICE ADMINISTRATION-OPER	05.020
489	OFFICE ADMINISTRATION-OPER	05.020
490	OFFICE ADMINISTRATION-OPER	05.025
491	OFFICE ADMINISTRATION-OPER	05.025
492	OFFICE ADMINISTRATION-OPER	05.025
493	OFFICE ADMINISTRATION-OPER	05.025
494	OFFICE ADMINISTRATION-OPER	05.025
495	OFFICE ADMINISTRATION-OPER	05.025
496	OFFICE ADMINISTRATION-OPER	05.025
497	OFFICE ADMINISTRATION-OPER	05.025
498	OFFICE ADMINISTRATION-OPER	05.025
499	OFFICE ADMINISTRATION-OPER	05.025
500	OFFICE ADMINISTRATION-OPER	05.025
501	OFFICE ADMINISTRATION-OPER	05.025
502	OFFICE ADMINISTRATION-OPER	05.025
503	OFFICE ADMINISTRATION-OPER	05.025
504	OFFICE ADMINISTRATION-OPER	05.025
505	OFFICE ADMINISTRATION-OPER	05.025
506	OFFICE ADMINISTRATION-OPER	05.025
507	OFFICE ADMINISTRATION-OPER	05.025
508	OFFICE ADMINISTRATION-OPER	05.025
509	OFFICE ADMINISTRATION-OPER	05.025
510	OFFICE ADMINISTRATION-OPER	05.025
511	OFFICE ADMINISTRATION-OPER	05.025
512	OFFICE ADMINISTRATION-OPER	05.025
513	OFFICE ADMINISTRATION-OPER	05.025
514	OFFICE ADMINISTRATION-OPER	05.025
515	OFFICE ADMINISTRATION-OPER	05.025
516	OFFICE ADMINISTRATION-OPER	05.025
517	OFFICE ADMINISTRATION-OPER	05.025
518	OFFICE ADMINISTRATION-OPER	05.025
519	OFFICE ADMINISTRATION-OPER	05.025
520	OFFICE ADMINISTRATION-OPER	05.025
521	OFFICE ADMINISTRATION-OPER	05.025
522	OFFICE ADMINISTRATION-OPER	05.025

Exhibit A

#	Agency	Budget Appropriation Line
523	OFFICE ADMINISTRATION-OPER	05.025
524	OFFICE ADMINISTRATION-OPER	05.025
525	OFFICE ADMINISTRATION-OPER	05.025
526	OFFICE ADMINISTRATION-OPER	05.025
527	OFFICE ADMINISTRATION-OPER	05.025
528	OFFICE ADMINISTRATION-OPER	05.025
529	OFFICE ADMINISTRATION-OPER	05.025
530	OFFICE ADMINISTRATION-OPER	05.025
531	OFFICE ADMINISTRATION-OPER	05.025
532	OFFICE ADMINISTRATION-OPER	05.025
533	OFFICE ADMINISTRATION-OPER	05.025
534	OFFICE ADMINISTRATION-OPER	05.025
535	OFFICE ADMINISTRATION-OPER	05.025
536	OFFICE ADMINISTRATION-OPER	05.025
537	OFFICE ADMINISTRATION-OPER	05.025
538	OFFICE ADMINISTRATION-OPER	05.025
539	OFFICE ADMINISTRATION-OPER	05.025
540	OFFICE ADMINISTRATION-OPER	05.025
541	OFFICE ADMINISTRATION-OPER	05.025
542	OFFICE ADMINISTRATION-OPER	05.025
543	OFFICE ADMINISTRATION-OPER	05.025
544	OFFICE ADMINISTRATION-OPER	05.025
545	OFFICE ADMINISTRATION-OPER	05.025
546	OFFICE ADMINISTRATION-OPER	05.025
547	OFFICE ADMINISTRATION-OPER	05.025
548	OFFICE ADMINISTRATION-OPER	05.025
549	OFFICE ADMINISTRATION-OPER	05.025
550	OFFICE ADMINISTRATION-OPER	05.025
551	OFFICE ADMINISTRATION-OPER	05.025
552	OFFICE ADMINISTRATION-OPER	05.025
553	OFFICE ADMINISTRATION-OPER	05.025
554	OFFICE ADMINISTRATION-OPER	05.025
555	OFFICE ADMINISTRATION-OPER	05.025
556	OFFICE ADMINISTRATION-OPER	05.025
557	OFFICE ADMINISTRATION-OPER	05.025
558	OFFICE ADMINISTRATION-OPER	05.025
559	OFFICE ADMINISTRATION-OPER	05.025
560	OFFICE ADMINISTRATION-OPER	05.025
561	OFFICE ADMINISTRATION-OPER	05.025
562	OFFICE ADMINISTRATION-OPER	05.025
563	OFFICE ADMINISTRATION-OPER	05.025
564	OFFICE ADMINISTRATION-OPER	05.025
565	OFFICE ADMINISTRATION-OPER	05.025
566	OFFICE ADMINISTRATION-OPER	05.025
567	OFFICE ADMINISTRATION-OPER	05.025
568	OFFICE ADMINISTRATION-OPER	05.025
569	OFFICE ADMINISTRATION-OPER	05.025
570	OFFICE ADMINISTRATION-OPER	05.025
571	OFFICE ADMINISTRATION-OPER	05.025
572	OFFICE ADMINISTRATION-OPER	05.025
573	OFFICE ADMINISTRATION-OPER	05.025
574	OFFICE ADMINISTRATION-OPER	05.025
575	OFFICE ADMINISTRATION-OPER	05.025
576	OFFICE ADMINISTRATION-OPER	05.025
577	OFFICE ADMINISTRATION-OPER	05.025
578	OFFICE ADMINISTRATION-OPER	05.025
579	OFFICE ADMINISTRATION-OPER	05.030
580	OFFICE ADMINISTRATION-OPER	05.030

Exhibit A

#	Agency	Budget Appropriation Line
581	OFFICE ADMINISTRATION-OPER	05.030
582	OFFICE ADMINISTRATION-OPER	05.030
583	OFFICE ADMINISTRATION-OPER	05.030
584	OFFICE ADMINISTRATION-OPER	05.030
585	OFFICE ADMINISTRATION-OPER	05.030
586	OFFICE ADMINISTRATION-OPER	05.030
587	OFFICE ADMINISTRATION-OPER	05.030
588	OFFICE ADMINISTRATION-OPER	05.030
589	OFFICE ADMINISTRATION-OPER	05.030
590	OFFICE ADMINISTRATION-OPER	05.030
591	OFFICE ADMINISTRATION-OPER	05.030
592	OFFICE ADMINISTRATION-OPER	05.030
593	OFFICE ADMINISTRATION-OPER	05.030
594	OFFICE ADMINISTRATION-OPER	05.030
595	OFFICE ADMINISTRATION-OPER	05.030
596	OFFICE ADMINISTRATION-OPER	05.030
597	OFFICE ADMINISTRATION-OPER	05.030
598	OFFICE ADMINISTRATION-OPER	05.030
599	OFFICE ADMINISTRATION-OPER	05.030
600	OFFICE ADMINISTRATION-OPER	05.030
601	OFFICE ADMINISTRATION-OPER	05.030
602	OFFICE ADMINISTRATION-OPER	05.030
603	OFFICE ADMINISTRATION-OPER	05.030
604	OFFICE ADMINISTRATION-OPER	05.030
605	OFFICE ADMINISTRATION-OPER	05.030
606	OFFICE ADMINISTRATION-OPER	05.030
607	OFFICE ADMINISTRATION-OPER	05.030
608	OFFICE ADMINISTRATION-OPER	05.030
609	OFFICE ADMINISTRATION-OPER	05.030
610	OFFICE ADMINISTRATION-OPER	05.030
611	OFFICE ADMINISTRATION-OPER	05.030
612	OFFICE ADMINISTRATION-OPER	05.030
613	OFFICE ADMINISTRATION-OPER	05.030
614	OFFICE ADMINISTRATION-OPER	05.030
615	OFFICE ADMINISTRATION-OPER	05.030
616	OFFICE ADMINISTRATION-OPER	05.030
617	OFFICE ADMINISTRATION-OPER	05.030
618	OFFICE ADMINISTRATION-OPER	05.030
619	OFFICE ADMINISTRATION-OPER	05.030
620	OFFICE ADMINISTRATION-OPER	05.030
621	OFFICE ADMINISTRATION-OPER	05.030
622	OFFICE ADMINISTRATION-OPER	05.030
623	OFFICE ADMINISTRATION-OPER	05.030
624	OFFICE ADMINISTRATION-OPER	05.030
625	OFFICE ADMINISTRATION-OPER	05.030
626	OFFICE ADMINISTRATION-OPER	05.030
627	OFFICE ADMINISTRATION-OPER	05.030
628	OFFICE ADMINISTRATION-OPER	05.030
629	OFFICE ADMINISTRATION-OPER	05.030
630	OFFICE ADMINISTRATION-OPER	05.030
631	OFFICE ADMINISTRATION-OPER	05.030
632	OFFICE ADMINISTRATION-OPER	05.030
633	OFFICE ADMINISTRATION-OPER	05.030
634	OFFICE ADMINISTRATION-OPER	05.030
635	OFFICE ADMINISTRATION-OPER	05.030
636	OFFICE ADMINISTRATION-OPER	05.030
637	OFFICE ADMINISTRATION-OPER	05.030
638	OFFICE ADMINISTRATION-OPER	05.030

Exhibit A

#	Agency	Budget Appropriation Line
639	OFFICE ADMINISTRATION-OPER	05.030
640	OFFICE ADMINISTRATION-OPER	05.030
641	OFFICE ADMINISTRATION-OPER	05.030
642	OFFICE ADMINISTRATION-OPER	05.030
643	OFFICE ADMINISTRATION-OPER	05.030
644	OFFICE ADMINISTRATION-OPER	05.030
645	OFFICE ADMINISTRATION-OPER	05.030
646	OFFICE ADMINISTRATION-OPER	05.030
647	OFFICE ADMINISTRATION-OPER	05.030
648	OFFICE ADMINISTRATION-OPER	05.030
649	OFFICE ADMINISTRATION-OPER	05.030
650	OFFICE ADMINISTRATION-OPER	05.030
651	OFFICE ADMINISTRATION-OPER	05.030
652	OFFICE ADMINISTRATION-OPER	05.030
653	OFFICE ADMINISTRATION-OPER	05.030
654	OFFICE ADMINISTRATION-OPER	05.030
655	OFFICE ADMINISTRATION-OPER	05.030
656	OFFICE ADMINISTRATION-OPER	05.030
657	OFFICE ADMINISTRATION-OPER	05.030
658	OFFICE ADMINISTRATION-OPER	05.030
659	OFFICE ADMINISTRATION-OPER	05.030
660	OFFICE ADMINISTRATION-OPER	05.030
661	OFFICE ADMINISTRATION-OPER	05.030
662	OFFICE ADMINISTRATION-OPER	05.030
663	OFFICE ADMINISTRATION-OPER	05.030
664	OFFICE ADMINISTRATION-OPER	05.030
665	OFFICE ADMINISTRATION-OPER	05.030
666	OFFICE ADMINISTRATION-OPER	05.030
667	OFFICE ADMINISTRATION-OPER	05.030
668	OFFICE ADMINISTRATION-OPER	05.030
669	OFFICE ADMINISTRATION-OPER	05.030
670	OFFICE ADMINISTRATION-OPER	05.030
671	OFFICE ADMINISTRATION-OPER	05.030
672	OFFICE ADMINISTRATION-OPER	05.030
673	OFFICE ADMINISTRATION-OPER	05.030
674	OFFICE ADMINISTRATION-OPER	05.030
675	OFFICE ADMINISTRATION-OPER	05.030
676	OFFICE ADMINISTRATION-OPER	05.035
677	OFFICE ADMINISTRATION-OPER	05.040
678	OFFICE ADMINISTRATION-OPER	05.040
679	OFFICE ADMINISTRATION-OPER	05.045
680	OFFICE ADMINISTRATION-OPER	05.045
681	OFFICE ADMINISTRATION-OPER	05.045
682	OFFICE ADMINISTRATION-OPER	05.050
683	OFFICE ADMINISTRATION-OPER	05.050
684	OFFICE ADMINISTRATION-OPER	05.050
685	OFFICE ADMINISTRATION-OPER	05.050
686	OFFICE ADMINISTRATION-OPER	05.050
687	OFFICE ADMINISTRATION-OPER	05.050
688	OFFICE ADMINISTRATION-OPER	05.051
689	OFFICE ADMINISTRATION-OPER	05.051
690	OFFICE ADMINISTRATION-OPER	05.051
691	OFFICE ADMINISTRATION-OPER	05.052
692	OFFICE ADMINISTRATION-OPER	05.052
693	OFFICE ADMINISTRATION-OPER	05.052
694	OFFICE ADMINISTRATION-OPER	05.053
695	OFFICE ADMINISTRATION-OPER	05.055
696	OFFICE ADMINISTRATION-OPER	05.055

Exhibit A

#	Agency	Budget Appropriation Line
697	OFFICE ADMINISTRATION-OPER	05.055
698	OFFICE ADMINISTRATION-OPER	05.055
699	OFFICE ADMINISTRATION-OPER	05.055
700	OFFICE ADMINISTRATION-OPER	05.055
701	OFFICE ADMINISTRATION-OPER	05.060
702	OFFICE ADMINISTRATION-OPER	05.065
703	OFFICE ADMINISTRATION-OPER	05.070
704	OFFICE ADMINISTRATION-OPER	05.070
705	OFFICE ADMINISTRATION-OPER	05.070
706	OFFICE ADMINISTRATION-OPER	05.075
707	OFFICE ADMINISTRATION-OPER	05.080
708	OFFICE ADMINISTRATION-OPER	05.085
709	OFFICE ADMINISTRATION-OPER	05.085
710	OFFICE ADMINISTRATION-OPER	05.085
711	OFFICE ADMINISTRATION-OPER	05.085
712	OFFICE ADMINISTRATION-OPER	05.090
713	OFFICE ADMINISTRATION-OPER	05.090
714	OFFICE ADMINISTRATION-OPER	05.090
715	OFFICE ADMINISTRATION-OPER	05.090
716	OFFICE ADMINISTRATION-OPER	05.095
717	OFFICE ADMINISTRATION-OPER	05.100
718	OFFICE ADMINISTRATION-OPER	05.105
719	OFFICE ADMINISTRATION-OPER	05.110
720	OFFICE ADMINISTRATION-OPER	05.115
721	OFFICE ADMINISTRATION-OPER	05.120
722	OFFICE ADMINISTRATION-OPER	05.125
723	OFFICE ADMINISTRATION-OPER	05.130
724	OFFICE ADMINISTRATION-OPER	05.130
725	OFFICE ADMINISTRATION-OPER	05.130
726	OFFICE ADMINISTRATION-OPER	05.131
727	OFFICE ADMINISTRATION-OPER	05.135
728	OFFICE ADMINISTRATION-OPER	05.140
729	OFFICE ADMINISTRATION-OPER	05.140
730	OFFICE ADMINISTRATION-OPER	05.140
731	OFFICE ADMINISTRATION-OPER	05.140
732	OFFICE ADMINISTRATION-OPER	05.145
733	OFFICE ADMINISTRATION-OPER	05.145
734	OFFICE ADMINISTRATION-OPER	05.145
735	OFFICE ADMINISTRATION-OPER	05.145
736	OFFICE ADMINISTRATION-OPER	05.150
737	OFFICE ADMINISTRATION-OPER	05.150
738	OFFICE ADMINISTRATION-OPER	05.150
739	OFFICE ADMINISTRATION-OPER	05.150
740	OFFICE ADMINISTRATION-OPER	05.155
741	OFFICE ADMINISTRATION-OPER	05.155
742	OFFICE ADMINISTRATION-OPER	05.160
743	OFFICE ADMINISTRATION-OPER	05.160
744	OFFICE ADMINISTRATION-OPER	05.165
745	OFFICE ADMINISTRATION-OPER	05.170
746	OFFICE ADMINISTRATION-OPER	05.170
747	OFFICE ADMINISTRATION-OPER	05.170
748	OFFICE ADMINISTRATION-OPER	05.170
749	OFFICE ADMINISTRATION-OPER	05.180
750	OFFICE ADMINISTRATION-OPER	05.180
751	OFFICE ADMINISTRATION-OPER	05.185
752	OFFICE ADMINISTRATION-OPER	05.190
753	OFFICE ADMINISTRATION-OPER	05.195
754	OFFICE ADMINISTRATION-OPER	05.200

Exhibit A

#	Agency	Budget Appropriation Line
755	OFFICE ADMINISTRATION-OPER	05.210
756	OFFICE ADMINISTRATION-OPER	05.215
757	OFFICE ADMINISTRATION-OPER	05.220
758	OFFICE ADMINISTRATION-OPER	05.225
759	OFFICE ADMINISTRATION-OPER	05.230
760	OFFICE ADMINISTRATION-OPER	05.235
761	OFFICE ADMINISTRATION-OPER	05.235
762	OFFICE ADMINISTRATION-OPER	05.235
763	OFFICE ADMINISTRATION-OPER	05.240
764	OFFICE ADMINISTRATION-OPER	05.240
765	OFFICE ADMINISTRATION-OPER	05.240
766	OFFICE ADMINISTRATION-OPER	05.245
767	OFFICE ADMINISTRATION-OPER	05.245
768	OFFICE ADMINISTRATION-OPER	05.250
769	OFFICE ADMINISTRATION-OPER	05.250
770	OFFICE ADMINISTRATION-OPER	05.255
771	OFFICE ADMINISTRATION-OPER	05.255
772	OFFICE ADMINISTRATION-OPER	05.260
773	OFFICE ADMINISTRATION-OPER	05.265
774	OFFICE ADMINISTRATION-OPER	05.270
775	OFFICE ADMINISTRATION-OPER	05.275
776	OFFICE ADMINISTRATION-OPER	05.280
777	OFFICE ADMINISTRATION-OPER	05.290
778	OFFICE ADMINISTRATION-OPER	05.290
779	OFFICE ADMINISTRATION-OPER	05.291
780	OFFICE ADMINISTRATION-OPER	05.450
781	OFFICE ADMINISTRATION-OPER	05.450
782	OFFICE ADMINISTRATION-OPER	05.450
783	OFFICE ADMINISTRATION-OPER	05.455
784	OFFICE ADMINISTRATION-OPER	05.460
785	OFFICE ADMINISTRATION-OPER	05.465
786	OFFICE ADMINISTRATION-OPER	05.465
787	OFFICE ADMINISTRATION-OPER	05.465
788	OFFICE ADMINISTRATION-OPER	05.470
789	OFFICE ADMINISTRATION-OPER	05.475
790	OFFICE ADMINISTRATION-OPER	05.475
791	OFFICE ADMINISTRATION-OPER	05.475
792	OFFICE ADMINISTRATION-OPER	05.475
793	OFFICE ADMINISTRATION-OPER	05.475
794	OFFICE ADMINISTRATION-OPER	05.480
795	OFFICE ADMINISTRATION-OPER	05.480
796	OFFICE ADMINISTRATION-OPER	05.480
797	OFFICE ADMINISTRATION-OPER	05.485
798	OFFICE ADMINISTRATION-OPER	05.490
799	OFFICE ADMINISTRATION-OPER	05.490
800	OFFICE ADMINISTRATION-OPER	05.490
801	OFFICE ADMINISTRATION-OPER	05.495
802	OFFICE ADMINISTRATION-OPER	05.505
803	OFFICE ADMINISTRATION-OPER	05.510
804	OFFICE ADMINISTRATION-OPER	05.520
805	OFFICE ADMINISTRATION-OPER	05.520
806	OFFICE ADMINISTRATION-OPER	05.525
807	OFFICE ADMINISTRATION-OPER	05.525
808	OFFICE ADMINISTRATION-OPER	05.530
809	OFFICE ADMINISTRATION-OPER	05.530
810	AGRICULTURE-OPERATING	06.005
811	AGRICULTURE-OPERATING	06.005
812	AGRICULTURE-OPERATING	06.005

Exhibit A

#	Agency	Budget Appropriation Line
813	AGRICULTURE-OPERATING	06.005
814	AGRICULTURE-OPERATING	06.005
815	AGRICULTURE-OPERATING	06.005
816	AGRICULTURE-OPERATING	06.005
817	AGRICULTURE-OPERATING	06.005
818	AGRICULTURE-OPERATING	06.005
819	AGRICULTURE-OPERATING	06.005
820	AGRICULTURE-OPERATING	06.005
821	AGRICULTURE-OPERATING	06.005
822	AGRICULTURE-OPERATING	06.005
823	AGRICULTURE-OPERATING	06.005
824	AGRICULTURE-OPERATING	06.005
825	AGRICULTURE-OPERATING	06.005
826	AGRICULTURE-OPERATING	06.005
827	AGRICULTURE-OPERATING	06.005
828	AGRICULTURE-OPERATING	06.005
829	AGRICULTURE-OPERATING	06.005
830	AGRICULTURE-OPERATING	06.010
831	AGRICULTURE-OPERATING	06.015
832	AGRICULTURE-OPERATING	06.020
833	AGRICULTURE-OPERATING	06.025
834	AGRICULTURE-OPERATING	06.030
835	AGRICULTURE-OPERATING	06.030
836	AGRICULTURE-OPERATING	06.030
837	AGRICULTURE-OPERATING	06.030
838	AGRICULTURE-OPERATING	06.030
839	AGRICULTURE-OPERATING	06.030
840	AGRICULTURE-OPERATING	06.030
841	AGRICULTURE-OPERATING	06.030
842	AGRICULTURE-OPERATING	06.030
843	AGRICULTURE-OPERATING	06.030
844	AGRICULTURE-OPERATING	06.030
845	AGRICULTURE-OPERATING	06.030
846	AGRICULTURE-OPERATING	06.030
847	AGRICULTURE-OPERATING	06.030
848	AGRICULTURE-OPERATING	06.032
849	AGRICULTURE-OPERATING	06.032
850	AGRICULTURE-OPERATING	06.035
851	AGRICULTURE-OPERATING	06.035
852	AGRICULTURE-OPERATING	06.040
853	AGRICULTURE-OPERATING	06.040
854	AGRICULTURE-OPERATING	06.040
855	AGRICULTURE-OPERATING	06.040
856	AGRICULTURE-OPERATING	06.040
857	AGRICULTURE-OPERATING	06.050
858	AGRICULTURE-OPERATING	06.060
859	AGRICULTURE-OPERATING	06.070
860	AGRICULTURE-OPERATING	06.075
861	AGRICULTURE-OPERATING	06.075
862	AGRICULTURE-OPERATING	06.075
863	AGRICULTURE-OPERATING	06.080
864	AGRICULTURE-OPERATING	06.090
865	AGRICULTURE-OPERATING	06.090
866	AGRICULTURE-OPERATING	06.090
867	AGRICULTURE-OPERATING	06.090
868	AGRICULTURE-OPERATING	06.090
869	AGRICULTURE-OPERATING	06.090
870	AGRICULTURE-OPERATING	06.090

Exhibit A

#	Agency	Budget Appropriation Line
871	AGRICULTURE-OPERATING	06.090
872	AGRICULTURE-OPERATING	06.090
873	AGRICULTURE-OPERATING	06.090
874	AGRICULTURE-OPERATING	06.090
875	AGRICULTURE-OPERATING	06.090
876	AGRICULTURE-OPERATING	06.090
877	AGRICULTURE-OPERATING	06.090
878	AGRICULTURE-OPERATING	06.090
879	AGRICULTURE-OPERATING	06.090
880	AGRICULTURE-OPERATING	06.090
881	AGRICULTURE-OPERATING	06.100
882	AGRICULTURE-OPERATING	06.100
883	AGRICULTURE-OPERATING	06.100
884	AGRICULTURE-OPERATING	06.100
885	AGRICULTURE-OPERATING	06.100
886	AGRICULTURE-OPERATING	06.100
887	AGRICULTURE-OPERATING	06.100
888	AGRICULTURE-OPERATING	06.100
889	AGRICULTURE-OPERATING	06.100
890	AGRICULTURE-OPERATING	06.100
891	AGRICULTURE-OPERATING	06.105
892	AGRICULTURE-OPERATING	06.105
893	AGRICULTURE-OPERATING	06.105
894	AGRICULTURE-OPERATING	06.110
895	AGRICULTURE-OPERATING	06.110
896	AGRICULTURE-OPERATING	06.110
897	AGRICULTURE-OPERATING	06.110
898	AGRICULTURE-OPERATING	06.110
899	AGRICULTURE-OPERATING	06.110
900	AGRICULTURE-OPERATING	06.110
901	AGRICULTURE-OPERATING	06.110
902	AGRICULTURE-OPERATING	06.110
903	AGRICULTURE-OPERATING	06.110
904	AGRICULTURE-OPERATING	06.110
905	AGRICULTURE-OPERATING	06.110
906	AGRICULTURE-OPERATING	06.110
907	AGRICULTURE-OPERATING	06.115
908	AGRICULTURE-OPERATING	06.115
909	AGRICULTURE-OPERATING	06.115
910	AGRICULTURE-OPERATING	06.115
911	AGRICULTURE-OPERATING	06.115
912	AGRICULTURE-OPERATING	06.115
913	AGRICULTURE-OPERATING	06.115
914	AGRICULTURE-OPERATING	06.115
915	AGRICULTURE-OPERATING	06.120
916	AGRICULTURE-OPERATING	06.120
917	AGRICULTURE-OPERATING	06.120
918	AGRICULTURE-OPERATING	06.120
919	AGRICULTURE-OPERATING	06.120
920	AGRICULTURE-OPERATING	06.125
921	AGRICULTURE-OPERATING	06.125
922	AGRICULTURE-OPERATING	06.125
923	AGRICULTURE-OPERATING	06.130
924	AGRICULTURE-OPERATING	06.130
925	AGRICULTURE-OPERATING	06.132
926	AGRICULTURE-OPERATING	06.135
927	AGRICULTURE-OPERATING	06.135
928	AGRICULTURE-OPERATING	06.135

Exhibit A

#	Agency	Budget Appropriation Line
929	AGRICULTURE-OPERATING	06.135
930	AGRICULTURE-OPERATING	06.135
931	AGRICULTURE-OPERATING	06.135
932	AGRICULTURE-OPERATING	06.135
933	AGRICULTURE-OPERATING	06.140
934	NATURAL RESOURCES-OPER	06.200
935	NATURAL RESOURCES-OPER	06.200
936	NATURAL RESOURCES-OPER	06.200
937	NATURAL RESOURCES-OPER	06.200
938	NATURAL RESOURCES-OPER	06.200
939	NATURAL RESOURCES-OPER	06.200
940	NATURAL RESOURCES-OPER	06.200
941	NATURAL RESOURCES-OPER	06.200
942	NATURAL RESOURCES-OPER	06.200
943	NATURAL RESOURCES-OPER	06.200
944	NATURAL RESOURCES-OPER	06.200
945	NATURAL RESOURCES-OPER	06.200
946	NATURAL RESOURCES-OPER	06.225
947	NATURAL RESOURCES-OPER	06.225
948	NATURAL RESOURCES-OPER	06.225
949	NATURAL RESOURCES-OPER	06.225
950	NATURAL RESOURCES-OPER	06.225
951	NATURAL RESOURCES-OPER	06.225
952	NATURAL RESOURCES-OPER	06.225
953	NATURAL RESOURCES-OPER	06.225
954	NATURAL RESOURCES-OPER	06.225
955	NATURAL RESOURCES-OPER	06.225
956	NATURAL RESOURCES-OPER	06.225
957	NATURAL RESOURCES-OPER	06.225
958	NATURAL RESOURCES-OPER	06.225
959	NATURAL RESOURCES-OPER	06.225
960	NATURAL RESOURCES-OPER	06.225
961	NATURAL RESOURCES-OPER	06.225
962	NATURAL RESOURCES-OPER	06.225
963	NATURAL RESOURCES-OPER	06.225
964	NATURAL RESOURCES-OPER	06.225
965	NATURAL RESOURCES-OPER	06.225
966	NATURAL RESOURCES-OPER	06.225
967	NATURAL RESOURCES-OPER	06.225
968	NATURAL RESOURCES-OPER	06.225
969	NATURAL RESOURCES-OPER	06.225
970	NATURAL RESOURCES-OPER	06.225
971	NATURAL RESOURCES-OPER	06.225
972	NATURAL RESOURCES-OPER	06.225
973	NATURAL RESOURCES-OPER	06.225
974	NATURAL RESOURCES-OPER	06.225
975	NATURAL RESOURCES-OPER	06.225
976	NATURAL RESOURCES-OPER	06.225
977	NATURAL RESOURCES-OPER	06.225
978	NATURAL RESOURCES-OPER	06.225
979	NATURAL RESOURCES-OPER	06.225
980	NATURAL RESOURCES-OPER	06.225
981	NATURAL RESOURCES-OPER	06.225
982	NATURAL RESOURCES-OPER	06.225
983	NATURAL RESOURCES-OPER	06.225
984	NATURAL RESOURCES-OPER	06.225
985	NATURAL RESOURCES-OPER	06.225
986	NATURAL RESOURCES-OPER	06.225

Exhibit A

#	Agency	Budget Appropriation Line
987	NATURAL RESOURCES-OPER	06.225
988	NATURAL RESOURCES-OPER	06.225
989	NATURAL RESOURCES-OPER	06.225
990	NATURAL RESOURCES-OPER	06.225
991	NATURAL RESOURCES-OPER	06.225
992	NATURAL RESOURCES-OPER	06.225
993	NATURAL RESOURCES-OPER	06.225
994	NATURAL RESOURCES-OPER	06.225
995	NATURAL RESOURCES-OPER	06.225
996	NATURAL RESOURCES-OPER	06.225
997	NATURAL RESOURCES-OPER	06.225
998	NATURAL RESOURCES-OPER	06.225
999	NATURAL RESOURCES-OPER	06.225
1000	NATURAL RESOURCES-OPER	06.225
1001	NATURAL RESOURCES-OPER	06.225
1002	NATURAL RESOURCES-OPER	06.225
1003	NATURAL RESOURCES-OPER	06.225
1004	NATURAL RESOURCES-OPER	06.225
1005	NATURAL RESOURCES-OPER	06.225
1006	NATURAL RESOURCES-OPER	06.225
1007	NATURAL RESOURCES-OPER	06.225
1008	NATURAL RESOURCES-OPER	06.225
1009	NATURAL RESOURCES-OPER	06.225
1010	NATURAL RESOURCES-OPER	06.225
1011	NATURAL RESOURCES-OPER	06.225
1012	NATURAL RESOURCES-OPER	06.225
1013	NATURAL RESOURCES-OPER	06.225
1014	NATURAL RESOURCES-OPER	06.225
1015	NATURAL RESOURCES-OPER	06.225
1016	NATURAL RESOURCES-OPER	06.225
1017	NATURAL RESOURCES-OPER	06.225
1018	NATURAL RESOURCES-OPER	06.225
1019	NATURAL RESOURCES-OPER	06.225
1020	NATURAL RESOURCES-OPER	06.225
1021	NATURAL RESOURCES-OPER	06.225
1022	NATURAL RESOURCES-OPER	06.225
1023	NATURAL RESOURCES-OPER	06.225
1024	NATURAL RESOURCES-OPER	06.225
1025	NATURAL RESOURCES-OPER	06.225
1026	NATURAL RESOURCES-OPER	06.225
1027	NATURAL RESOURCES-OPER	06.225
1028	NATURAL RESOURCES-OPER	06.225
1029	NATURAL RESOURCES-OPER	06.225
1030	NATURAL RESOURCES-OPER	06.225
1031	NATURAL RESOURCES-OPER	06.225
1032	NATURAL RESOURCES-OPER	06.225
1033	NATURAL RESOURCES-OPER	06.225
1034	NATURAL RESOURCES-OPER	06.225
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1036	NATURAL RESOURCES-OPER	06.225
1037	NATURAL RESOURCES-OPER	06.225
1038	NATURAL RESOURCES-OPER	06.225
1039	NATURAL RESOURCES-OPER	06.225
1040	NATURAL RESOURCES-OPER	06.225
1041	NATURAL RESOURCES-OPER	06.225
1042	NATURAL RESOURCES-OPER	06.225
1043	NATURAL RESOURCES-OPER	06.225
1044	NATURAL RESOURCES-OPER	06.225

Exhibit A

#	Agency	Budget Appropriation Line
1045	NATURAL RESOURCES-OPER	06.225
1046	NATURAL RESOURCES-OPER	06.225
1047	NATURAL RESOURCES-OPER	06.225
1048	NATURAL RESOURCES-OPER	06.225
1049	NATURAL RESOURCES-OPER	06.225
1050	NATURAL RESOURCES-OPER	06.225
1051	NATURAL RESOURCES-OPER	06.225
1052	NATURAL RESOURCES-OPER	06.225
1053	NATURAL RESOURCES-OPER	06.225
1054	NATURAL RESOURCES-OPER	06.225
1055	NATURAL RESOURCES-OPER	06.225
1056	NATURAL RESOURCES-OPER	06.225
1057	NATURAL RESOURCES-OPER	06.225
1058	NATURAL RESOURCES-OPER	06.225
1059	NATURAL RESOURCES-OPER	06.225
1060	NATURAL RESOURCES-OPER	06.225
1061	NATURAL RESOURCES-OPER	06.225
1062	NATURAL RESOURCES-OPER	06.225
1063	NATURAL RESOURCES-OPER	06.225
1064	NATURAL RESOURCES-OPER	06.225
1065	NATURAL RESOURCES-OPER	06.225
1066	NATURAL RESOURCES-OPER	06.225
1067	NATURAL RESOURCES-OPER	06.225
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1072	NATURAL RESOURCES-OPER	06.225
1073	NATURAL RESOURCES-OPER	06.225
1074	NATURAL RESOURCES-OPER	06.225
1075	NATURAL RESOURCES-OPER	06.225
1076	NATURAL RESOURCES-OPER	06.225
1077	NATURAL RESOURCES-OPER	06.225
1078	NATURAL RESOURCES-OPER	06.225
1079	NATURAL RESOURCES-OPER	06.230
1080	NATURAL RESOURCES-OPER	06.230
1081	NATURAL RESOURCES-OPER	06.250
1082	NATURAL RESOURCES-OPER	06.250
1083	NATURAL RESOURCES-OPER	06.250
1084	NATURAL RESOURCES-OPER	06.250
1085	NATURAL RESOURCES-OPER	06.250
1086	NATURAL RESOURCES-OPER	06.250
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1091	NATURAL RESOURCES-OPER	06.250
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1093	NATURAL RESOURCES-OPER	06.250
1094	NATURAL RESOURCES-OPER	06.250
1095	NATURAL RESOURCES-OPER	06.250
1096	NATURAL RESOURCES-OPER	06.250
1097	NATURAL RESOURCES-OPER	06.250
1098	NATURAL RESOURCES-OPER	06.250
1099	NATURAL RESOURCES-OPER	06.250
1100	NATURAL RESOURCES-OPER	06.250
1101	NATURAL RESOURCES-OPER	06.250
1102	NATURAL RESOURCES-OPER	06.250

Exhibit A

#	Agency	Budget Appropriation Line
1103	NATURAL RESOURCES-OPER	06.250
1104	NATURAL RESOURCES-OPER	06.250
1105	NATURAL RESOURCES-OPER	06.250
1106	NATURAL RESOURCES-OPER	06.250
1107	NATURAL RESOURCES-OPER	06.250
1108	NATURAL RESOURCES-OPER	06.250
1109	NATURAL RESOURCES-OPER	06.250
1110	NATURAL RESOURCES-OPER	06.250
1111	NATURAL RESOURCES-OPER	06.250
1112	NATURAL RESOURCES-OPER	06.250
1113	NATURAL RESOURCES-OPER	06.250
1114	NATURAL RESOURCES-OPER	06.250
1115	NATURAL RESOURCES-OPER	06.250
1116	NATURAL RESOURCES-OPER	06.255
1117	NATURAL RESOURCES-OPER	06.260
1118	NATURAL RESOURCES-OPER	06.275
1119	NATURAL RESOURCES-OPER	06.275
1120	NATURAL RESOURCES-OPER	06.275
1121	NATURAL RESOURCES-OPER	06.275
1122	NATURAL RESOURCES-OPER	06.275
1123	NATURAL RESOURCES-OPER	06.275
1124	NATURAL RESOURCES-OPER	06.275
1125	NATURAL RESOURCES-OPER	06.275
1126	NATURAL RESOURCES-OPER	06.275
1127	NATURAL RESOURCES-OPER	06.275
1128	NATURAL RESOURCES-OPER	06.275
1129	NATURAL RESOURCES-OPER	06.275
1130	NATURAL RESOURCES-OPER	06.275
1131	NATURAL RESOURCES-OPER	06.275
1132	NATURAL RESOURCES-OPER	06.275
1133	NATURAL RESOURCES-OPER	06.275
1134	NATURAL RESOURCES-OPER	06.275
1135	NATURAL RESOURCES-OPER	06.275
1136	NATURAL RESOURCES-OPER	06.275
1137	NATURAL RESOURCES-OPER	06.275
1138	NATURAL RESOURCES-OPER	06.275
1139	NATURAL RESOURCES-OPER	06.275
1140	NATURAL RESOURCES-OPER	06.280
1141	NATURAL RESOURCES-OPER	06.280
1142	NATURAL RESOURCES-OPER	06.280
1143	NATURAL RESOURCES-OPER	06.280
1144	NATURAL RESOURCES-OPER	06.280
1145	NATURAL RESOURCES-OPER	06.280
1146	NATURAL RESOURCES-OPER	06.280
1147	NATURAL RESOURCES-OPER	06.280
1148	NATURAL RESOURCES-OPER	06.285
1149	NATURAL RESOURCES-OPER	06.285
1150	NATURAL RESOURCES-OPER	06.290
1151	NATURAL RESOURCES-OPER	06.290
1152	NATURAL RESOURCES-OPER	06.300
1153	NATURAL RESOURCES-OPER	06.305
1154	NATURAL RESOURCES-OPER	06.305
1155	NATURAL RESOURCES-OPER	06.310
1156	NATURAL RESOURCES-OPER	06.315
1157	NATURAL RESOURCES-OPER	06.315
1158	NATURAL RESOURCES-OPER	06.320
1159	NATURAL RESOURCES-OPER	06.325
1160	NATURAL RESOURCES-OPER	06.335

Exhibit A

#	Agency	Budget Appropriation Line
1161	NATURAL RESOURCES-OPER	06.335
1162	NATURAL RESOURCES-OPER	06.335
1163	NATURAL RESOURCES-OPER	06.335
1164	NATURAL RESOURCES-OPER	06.340
1165	CONSERVATION-OPERATING	06.600
1166	CONSERVATION-OPERATING	06.600
1167	CONSERVATION-OPERATING	06.605
1168	CONSERVATION-OPERATING	06.605
1169	CONSERVATION-OPERATING	06.610
1170	CONSERVATION-OPERATING	06.610
1171	CONSERVATION-OPERATING	06.610
1172	CONSERVATION-OPERATING	06.615
1173	CONSERVATION-OPERATING	06.615
1174	CONSERVATION-OPERATING	06.620
1175	CONSERVATION-OPERATING	06.620
1176	CONSERVATION-OPERATING	06.625
1177	CONSERVATION-OPERATING	06.625
1178	CONSERVATION-OPERATING	06.630
1179	CONSERVATION-OPERATING	06.630
1180	CONSERVATION-OPERATING	06.635
1181	CONSERVATION-OPERATING	06.635
1182	CONSERVATION-OPERATING	06.640
1183	CONSERVATION-OPERATING	06.640
1184	CONSERVATION-OPERATING	06.641
1185	CONSERVATION-OPERATING	06.645
1186	CONSERVATION-OPERATING	06.645
1187	CONSERVATION-OPERATING	06.650
1188	CONSERVATION-OPERATING	06.650
1189	CONSERVATION-OPERATING	06.651
1190	ECONOMIC DEVELOP-OPER	07.005
1191	ECONOMIC DEVELOP-OPER	07.005
1192	ECONOMIC DEVELOP-OPER	07.005
1193	ECONOMIC DEVELOP-OPER	07.005
1194	ECONOMIC DEVELOP-OPER	07.005
1195	ECONOMIC DEVELOP-OPER	07.005
1196	ECONOMIC DEVELOP-OPER	07.005
1197	ECONOMIC DEVELOP-OPER	07.005
1198	ECONOMIC DEVELOP-OPER	07.005
1199	ECONOMIC DEVELOP-OPER	07.010
1200	ECONOMIC DEVELOP-OPER	07.010
1201	ECONOMIC DEVELOP-OPER	07.010
1202	ECONOMIC DEVELOP-OPER	07.010
1203	ECONOMIC DEVELOP-OPER	07.010
1204	ECONOMIC DEVELOP-OPER	07.010
1205	ECONOMIC DEVELOP-OPER	07.010
1206	ECONOMIC DEVELOP-OPER	07.015
1207	ECONOMIC DEVELOP-OPER	07.015
1208	ECONOMIC DEVELOP-OPER	07.015
1209	ECONOMIC DEVELOP-OPER	07.015
1210	ECONOMIC DEVELOP-OPER	07.015
1211	ECONOMIC DEVELOP-OPER	07.015
1212	ECONOMIC DEVELOP-OPER	07.015
1213	ECONOMIC DEVELOP-OPER	07.015
1214	ECONOMIC DEVELOP-OPER	07.015
1215	ECONOMIC DEVELOP-OPER	07.015
1216	ECONOMIC DEVELOP-OPER	07.015
1217	ECONOMIC DEVELOP-OPER	07.015
1218	ECONOMIC DEVELOP-OPER	07.015

Exhibit A

#	Agency	Budget Appropriation Line
1219	ECONOMIC DEVELOP-OPER	07.015
1220	ECONOMIC DEVELOP-OPER	07.015
1221	ECONOMIC DEVELOP-OPER	07.015
1222	ECONOMIC DEVELOP-OPER	07.015
1223	ECONOMIC DEVELOP-OPER	07.015
1224	ECONOMIC DEVELOP-OPER	07.015
1225	ECONOMIC DEVELOP-OPER	07.030
1226	ECONOMIC DEVELOP-OPER	07.030
1227	ECONOMIC DEVELOP-OPER	07.035
1228	ECONOMIC DEVELOP-OPER	07.040
1229	ECONOMIC DEVELOP-OPER	07.045
1230	ECONOMIC DEVELOP-OPER	07.045
1231	ECONOMIC DEVELOP-OPER	07.045
1232	ECONOMIC DEVELOP-OPER	07.045
1233	ECONOMIC DEVELOP-OPER	07.045
1234	ECONOMIC DEVELOP-OPER	07.045
1235	ECONOMIC DEVELOP-OPER	07.050
1236	ECONOMIC DEVELOP-OPER	07.050
1237	ECONOMIC DEVELOP-OPER	07.051
1238	ECONOMIC DEVELOP-OPER	07.055
1239	ECONOMIC DEVELOP-OPER	07.060
1240	ECONOMIC DEVELOP-OPER	07.065
1241	ECONOMIC DEVELOP-OPER	07.070
1242	ECONOMIC DEVELOP-OPER	07.075
1243	ECONOMIC DEVELOP-OPER	07.080
1244	ECONOMIC DEVELOP-OPER	07.085
1245	ECONOMIC DEVELOP-OPER	07.085
1246	ECONOMIC DEVELOP-OPER	07.085
1247	ECONOMIC DEVELOP-OPER	07.090
1248	ECONOMIC DEVELOP-OPER	07.090
1249	ECONOMIC DEVELOP-OPER	07.090
1250	ECONOMIC DEVELOP-OPER	07.090
1251	ECONOMIC DEVELOP-OPER	07.090
1252	ECONOMIC DEVELOP-OPER	07.090
1253	ECONOMIC DEVELOP-OPER	07.090
1254	ECONOMIC DEVELOP-OPER	07.090
1255	ECONOMIC DEVELOP-OPER	07.095
1256	ECONOMIC DEVELOP-OPER	07.100
1257	ECONOMIC DEVELOP-OPER	07.105
1258	ECONOMIC DEVELOP-OPER	07.110
1259	ECONOMIC DEVELOP-OPER	07.110
1260	ECONOMIC DEVELOP-OPER	07.110
1261	ECONOMIC DEVELOP-OPER	07.110
1262	ECONOMIC DEVELOP-OPER	07.110
1263	ECONOMIC DEVELOP-OPER	07.110
1264	ECONOMIC DEVELOP-OPER	07.115
1265	ECONOMIC DEVELOP-OPER	07.115
1266	ECONOMIC DEVELOP-OPER	07.115
1267	ECONOMIC DEVELOP-OPER	07.115
1268	ECONOMIC DEVELOP-OPER	07.115
1269	ECONOMIC DEVELOP-OPER	07.115
1270	ECONOMIC DEVELOP-OPER	07.115
1271	ECONOMIC DEVELOP-OPER	07.120
1272	ECONOMIC DEVELOP-OPER	07.125
1273	ECONOMIC DEVELOP-OPER	07.130
1274	ECONOMIC DEVELOP-OPER	07.135
1275	ECONOMIC DEVELOP-OPER	07.140
1276	ECONOMIC DEVELOP-OPER	07.140

Exhibit A

#	Agency	Budget Appropriation Line
1277	ECONOMIC DEVELOP-OPER	07.145
1278	ECONOMIC DEVELOP-OPER	07.145
1279	ECONOMIC DEVELOP-OPER	07.145
1280	ECONOMIC DEVELOP-OPER	07.145
1281	ECONOMIC DEVELOP-OPER	07.145
1282	ECONOMIC DEVELOP-OPER	07.145
1283	ECONOMIC DEVELOP-OPER	07.145
1284	ECONOMIC DEVELOP-OPER	07.150
1285	ECONOMIC DEVELOP-OPER	07.155
1286	ECONOMIC DEVELOP-OPER	07.155
1287	ECONOMIC DEVELOP-OPER	07.155
1288	ECONOMIC DEVELOP-OPER	07.155
1289	ECONOMIC DEVELOP-OPER	07.155
1290	ECONOMIC DEVELOP-OPER	07.155
1291	ECONOMIC DEVELOP-OPER	07.155
1292	ECONOMIC DEVELOP-OPER	07.155
1293	ECONOMIC DEVELOP-OPER	07.155
1294	ECONOMIC DEVELOP-OPER	07.155
1295	ECONOMIC DEVELOP-OPER	07.155
1296	ECONOMIC DEVELOP-OPER	07.155
1297	ECONOMIC DEVELOP-OPER	07.155
1298	ECONOMIC DEVELOP-OPER	07.155
1299	ECONOMIC DEVELOP-OPER	07.155
1300	ECONOMIC DEVELOP-OPER	07.155
1301	ECONOMIC DEVELOP-OPER	07.155
1302	ECONOMIC DEVELOP-OPER	07.155
1303	ECONOMIC DEVELOP-OPER	07.155
1304	ECONOMIC DEVELOP-OPER	07.155
1305	ECONOMIC DEVELOP-OPER	07.155
1306	ECONOMIC DEVELOP-OPER	07.155
1307	ECONOMIC DEVELOP-OPER	07.160
1308	ECONOMIC DEVELOP-OPER	07.165
1309	ECONOMIC DEVELOP-OPER	07.165
1310	ECONOMIC DEVELOP-OPER	07.165
1311	ECONOMIC DEVELOP-OPER	07.165
1312	ECONOMIC DEVELOP-OPER	07.165
1313	ECONOMIC DEVELOP-OPER	07.170
1314	ECONOMIC DEVELOP-OPER	07.175
1315	ECONOMIC DEVELOP-OPER	07.175
1316	ECONOMIC DEVELOP-OPER	07.180
1317	ECONOMIC DEVELOP-OPER	07.180
1318	ECONOMIC DEVELOP-OPER	07.180
1319	ECONOMIC DEVELOP-OPER	07.180
1320	ECONOMIC DEVELOP-OPER	07.181
1321	DIFP-OPERATING	07.400
1322	DIFP-OPERATING	07.400
1323	DIFP-OPERATING	07.405
1324	DIFP-OPERATING	07.405
1325	DIFP-OPERATING	07.405
1326	DIFP-OPERATING	07.405
1327	DIFP-OPERATING	07.410
1328	DIFP-OPERATING	07.410
1329	DIFP-OPERATING	07.410
1330	DIFP-OPERATING	07.415
1331	DIFP-OPERATING	07.415
1332	DIFP-OPERATING	07.420
1333	DIFP-OPERATING	07.420
1334	DIFP-OPERATING	07.425

Exhibit A

#	Agency	Budget Appropriation Line
1335	DIFP-OPERATING	07.425
1336	DIFP-OPERATING	07.430
1337	DIFP-OPERATING	07.430
1338	DIFP-OPERATING	07.435
1339	DIFP-OPERATING	07.435
1340	DIFP-OPERATING	07.435
1341	DIFP-OPERATING	07.435
1342	DIFP-OPERATING	07.440
1343	DIFP-OPERATING	07.445
1344	DIFP-OPERATING	07.450
1345	DIFP-OPERATING	07.455
1346	DIFP-OPERATING	07.455
1347	DIFP-OPERATING	07.455
1348	DIFP-OPERATING	07.455
1349	DIFP-OPERATING	07.455
1350	DIFP-OPERATING	07.460
1351	DIFP-OPERATING	07.460
1352	DIFP-OPERATING	07.465
1353	DIFP-OPERATING	07.465
1354	DIFP-OPERATING	07.470
1355	DIFP-OPERATING	07.475
1356	DIFP-OPERATING	07.475
1357	DIFP-OPERATING	07.480
1358	DIFP-OPERATING	07.480
1359	DIFP-OPERATING	07.485
1360	DIFP-OPERATING	07.490
1361	DIFP-OPERATING	07.490
1362	DIFP-OPERATING	07.495
1363	DIFP-OPERATING	07.495
1364	DIFP-OPERATING	07.495
1365	DIFP-OPERATING	07.500
1366	DIFP-OPERATING	07.505
1367	DIFP-OPERATING	07.505
1368	DIFP-OPERATING	07.505
1369	DIFP-OPERATING	07.510
1370	DIFP-OPERATING	07.515
1371	DIFP-OPERATING	07.515
1372	DIFP-OPERATING	07.520
1373	DIFP-OPERATING	07.520
1374	DIFP-OPERATING	07.525
1375	DIFP-OPERATING	07.530
1376	DIFP-OPERATING	07.535
1377	DIFP-OPERATING	07.540
1378	LABOR & INDUSTRIAL REL-OPER	07.800
1379	LABOR & INDUSTRIAL REL-OPER	07.800
1380	LABOR & INDUSTRIAL REL-OPER	07.800
1381	LABOR & INDUSTRIAL REL-OPER	07.800
1382	LABOR & INDUSTRIAL REL-OPER	07.805
1383	LABOR & INDUSTRIAL REL-OPER	07.805
1384	LABOR & INDUSTRIAL REL-OPER	07.805
1385	LABOR & INDUSTRIAL REL-OPER	07.805
1386	LABOR & INDUSTRIAL REL-OPER	07.810
1387	LABOR & INDUSTRIAL REL-OPER	07.810
1388	LABOR & INDUSTRIAL REL-OPER	07.810
1389	LABOR & INDUSTRIAL REL-OPER	07.810
1390	LABOR & INDUSTRIAL REL-OPER	07.810
1391	LABOR & INDUSTRIAL REL-OPER	07.815
1392	LABOR & INDUSTRIAL REL-OPER	07.815

Exhibit A

#	Agency	Budget Appropriation Line
1393	LABOR & INDUSTRIAL REL-OPER	07.815
1394	LABOR & INDUSTRIAL REL-OPER	07.815
1395	LABOR & INDUSTRIAL REL-OPER	07.815
1396	LABOR & INDUSTRIAL REL-OPER	07.815
1397	LABOR & INDUSTRIAL REL-OPER	07.820
1398	LABOR & INDUSTRIAL REL-OPER	07.820
1399	LABOR & INDUSTRIAL REL-OPER	07.820
1400	LABOR & INDUSTRIAL REL-OPER	07.820
1401	LABOR & INDUSTRIAL REL-OPER	07.820
1402	LABOR & INDUSTRIAL REL-OPER	07.820
1403	LABOR & INDUSTRIAL REL-OPER	07.820
1404	LABOR & INDUSTRIAL REL-OPER	07.820
1405	LABOR & INDUSTRIAL REL-OPER	07.825
1406	LABOR & INDUSTRIAL REL-OPER	07.825
1407	LABOR & INDUSTRIAL REL-OPER	07.825
1408	LABOR & INDUSTRIAL REL-OPER	07.825
1409	LABOR & INDUSTRIAL REL-OPER	07.830
1410	LABOR & INDUSTRIAL REL-OPER	07.830
1411	LABOR & INDUSTRIAL REL-OPER	07.830
1412	LABOR & INDUSTRIAL REL-OPER	07.830
1413	LABOR & INDUSTRIAL REL-OPER	07.830
1414	LABOR & INDUSTRIAL REL-OPER	07.830
1415	LABOR & INDUSTRIAL REL-OPER	07.830
1416	LABOR & INDUSTRIAL REL-OPER	07.830
1417	LABOR & INDUSTRIAL REL-OPER	07.835
1418	LABOR & INDUSTRIAL REL-OPER	07.835
1419	LABOR & INDUSTRIAL REL-OPER	07.840
1420	LABOR & INDUSTRIAL REL-OPER	07.840
1421	LABOR & INDUSTRIAL REL-OPER	07.840
1422	LABOR & INDUSTRIAL REL-OPER	07.840
1423	LABOR & INDUSTRIAL REL-OPER	07.840
1424	LABOR & INDUSTRIAL REL-OPER	07.840
1425	LABOR & INDUSTRIAL REL-OPER	07.845
1426	LABOR & INDUSTRIAL REL-OPER	07.850
1427	LABOR & INDUSTRIAL REL-OPER	07.855
1428	LABOR & INDUSTRIAL REL-OPER	07.860
1429	LABOR & INDUSTRIAL REL-OPER	07.865
1430	LABOR & INDUSTRIAL REL-OPER	07.870
1431	LABOR & INDUSTRIAL REL-OPER	07.875
1432	LABOR & INDUSTRIAL REL-OPER	07.880
1433	LABOR & INDUSTRIAL REL-OPER	07.880
1434	LABOR & INDUSTRIAL REL-OPER	07.880
1435	LABOR & INDUSTRIAL REL-OPER	07.880
1436	LABOR & INDUSTRIAL REL-OPER	07.885
1437	LABOR & INDUSTRIAL REL-OPER	07.890
1438	LABOR & INDUSTRIAL REL-OPER	07.890
1439	LABOR & INDUSTRIAL REL-OPER	07.895
1440	LABOR & INDUSTRIAL REL-OPER	07.895
1441	LABOR & INDUSTRIAL REL-OPER	07.900
1442	LABOR & INDUSTRIAL REL-OPER	07.905
1443	LABOR & INDUSTRIAL REL-OPER	07.905
1444	LABOR & INDUSTRIAL REL-OPER	07.905
1445	LABOR & INDUSTRIAL REL-OPER	07.905
1446	LABOR & INDUSTRIAL REL-OPER	07.905
1447	LABOR & INDUSTRIAL REL-OPER	07.905
1448	LABOR & INDUSTRIAL REL-OPER	07.910
1449	PUBLIC SAFETY-OPERATING	08.005
1450	PUBLIC SAFETY-OPERATING	08.005

Exhibit A

#	Agency	Budget Appropriation Line
1451	PUBLIC SAFETY-OPERATING	08.005
1452	PUBLIC SAFETY-OPERATING	08.005
1453	PUBLIC SAFETY-OPERATING	08.005
1454	PUBLIC SAFETY-OPERATING	08.005
1455	PUBLIC SAFETY-OPERATING	08.005
1456	PUBLIC SAFETY-OPERATING	08.005
1457	PUBLIC SAFETY-OPERATING	08.005
1458	PUBLIC SAFETY-OPERATING	08.005
1459	PUBLIC SAFETY-OPERATING	08.005
1460	PUBLIC SAFETY-OPERATING	08.005
1461	PUBLIC SAFETY-OPERATING	08.005
1462	PUBLIC SAFETY-OPERATING	08.005
1463	PUBLIC SAFETY-OPERATING	08.005
1464	PUBLIC SAFETY-OPERATING	08.005
1465	PUBLIC SAFETY-OPERATING	08.005
1466	PUBLIC SAFETY-OPERATING	08.005
1467	PUBLIC SAFETY-OPERATING	08.005
1468	PUBLIC SAFETY-OPERATING	08.005
1469	PUBLIC SAFETY-OPERATING	08.005
1470	PUBLIC SAFETY-OPERATING	08.010
1471	PUBLIC SAFETY-OPERATING	08.015
1472	PUBLIC SAFETY-OPERATING	08.020
1473	PUBLIC SAFETY-OPERATING	08.025
1474	PUBLIC SAFETY-OPERATING	08.030
1475	PUBLIC SAFETY-OPERATING	08.030
1476	PUBLIC SAFETY-OPERATING	08.030
1477	PUBLIC SAFETY-OPERATING	08.035
1478	PUBLIC SAFETY-OPERATING	08.040
1479	PUBLIC SAFETY-OPERATING	08.045
1480	PUBLIC SAFETY-OPERATING	08.045
1481	PUBLIC SAFETY-OPERATING	08.050
1482	PUBLIC SAFETY-OPERATING	08.050
1483	PUBLIC SAFETY-OPERATING	08.050
1484	PUBLIC SAFETY-OPERATING	08.050
1485	PUBLIC SAFETY-OPERATING	08.050
1486	PUBLIC SAFETY-OPERATING	08.055
1487	PUBLIC SAFETY-OPERATING	08.060
1488	PUBLIC SAFETY-OPERATING	08.065
1489	PUBLIC SAFETY-OPERATING	08.070
1490	PUBLIC SAFETY-OPERATING	08.075
1491	PUBLIC SAFETY-OPERATING	08.075
1492	PUBLIC SAFETY-OPERATING	08.080
1493	PUBLIC SAFETY-OPERATING	08.080
1494	PUBLIC SAFETY-OPERATING	08.080
1495	PUBLIC SAFETY-OPERATING	08.080
1496	PUBLIC SAFETY-OPERATING	08.080
1497	PUBLIC SAFETY-OPERATING	08.080
1498	PUBLIC SAFETY-OPERATING	08.080
1499	PUBLIC SAFETY-OPERATING	08.080
1500	PUBLIC SAFETY-OPERATING	08.080
1501	PUBLIC SAFETY-OPERATING	08.085
1502	PUBLIC SAFETY-OPERATING	08.090
1503	PUBLIC SAFETY-OPERATING	08.090
1504	PUBLIC SAFETY-OPERATING	08.090
1505	PUBLIC SAFETY-OPERATING	08.090
1506	PUBLIC SAFETY-OPERATING	08.090
1507	PUBLIC SAFETY-OPERATING	08.090
1508	PUBLIC SAFETY-OPERATING	08.090

Exhibit A

#	Agency	Budget Appropriation Line
1509	PUBLIC SAFETY-OPERATING	08.090
1510	PUBLIC SAFETY-OPERATING	08.090
1511	PUBLIC SAFETY-OPERATING	08.090
1512	PUBLIC SAFETY-OPERATING	08.090
1513	PUBLIC SAFETY-OPERATING	08.090
1514	PUBLIC SAFETY-OPERATING	08.090
1515	PUBLIC SAFETY-OPERATING	08.090
1516	PUBLIC SAFETY-OPERATING	08.090
1517	PUBLIC SAFETY-OPERATING	08.090
1518	PUBLIC SAFETY-OPERATING	08.090
1519	PUBLIC SAFETY-OPERATING	08.090
1520	PUBLIC SAFETY-OPERATING	08.090
1521	PUBLIC SAFETY-OPERATING	08.095
1522	PUBLIC SAFETY-OPERATING	08.095
1523	PUBLIC SAFETY-OPERATING	08.095
1524	PUBLIC SAFETY-OPERATING	08.095
1525	PUBLIC SAFETY-OPERATING	08.095
1526	PUBLIC SAFETY-OPERATING	08.095
1527	PUBLIC SAFETY-OPERATING	08.095
1528	PUBLIC SAFETY-OPERATING	08.100
1529	PUBLIC SAFETY-OPERATING	08.100
1530	PUBLIC SAFETY-OPERATING	08.100
1531	PUBLIC SAFETY-OPERATING	08.105
1532	PUBLIC SAFETY-OPERATING	08.105
1533	PUBLIC SAFETY-OPERATING	08.105
1534	PUBLIC SAFETY-OPERATING	08.110
1535	PUBLIC SAFETY-OPERATING	08.110
1536	PUBLIC SAFETY-OPERATING	08.110
1537	PUBLIC SAFETY-OPERATING	08.110
1538	PUBLIC SAFETY-OPERATING	08.110
1539	PUBLIC SAFETY-OPERATING	08.110
1540	PUBLIC SAFETY-OPERATING	08.110
1541	PUBLIC SAFETY-OPERATING	08.110
1542	PUBLIC SAFETY-OPERATING	08.110
1543	PUBLIC SAFETY-OPERATING	08.110
1544	PUBLIC SAFETY-OPERATING	08.110
1545	PUBLIC SAFETY-OPERATING	08.115
1546	PUBLIC SAFETY-OPERATING	08.115
1547	PUBLIC SAFETY-OPERATING	08.115
1548	PUBLIC SAFETY-OPERATING	08.115
1549	PUBLIC SAFETY-OPERATING	08.115
1550	PUBLIC SAFETY-OPERATING	08.115
1551	PUBLIC SAFETY-OPERATING	08.115
1552	PUBLIC SAFETY-OPERATING	08.115
1553	PUBLIC SAFETY-OPERATING	08.120
1554	PUBLIC SAFETY-OPERATING	08.120
1555	PUBLIC SAFETY-OPERATING	08.120
1556	PUBLIC SAFETY-OPERATING	08.120
1557	PUBLIC SAFETY-OPERATING	08.120
1558	PUBLIC SAFETY-OPERATING	08.125
1559	PUBLIC SAFETY-OPERATING	08.130
1560	PUBLIC SAFETY-OPERATING	08.130
1561	PUBLIC SAFETY-OPERATING	08.130
1562	PUBLIC SAFETY-OPERATING	08.130
1563	PUBLIC SAFETY-OPERATING	08.130
1564	PUBLIC SAFETY-OPERATING	08.130
1565	PUBLIC SAFETY-OPERATING	08.130
1566	PUBLIC SAFETY-OPERATING	08.130

Exhibit A

#	Agency	Budget Appropriation Line
1567	PUBLIC SAFETY-OPERATING	08.130
1568	PUBLIC SAFETY-OPERATING	08.130
1569	PUBLIC SAFETY-OPERATING	08.130
1570	PUBLIC SAFETY-OPERATING	08.130
1571	PUBLIC SAFETY-OPERATING	08.130
1572	PUBLIC SAFETY-OPERATING	08.130
1573	PUBLIC SAFETY-OPERATING	08.135
1574	PUBLIC SAFETY-OPERATING	08.140
1575	PUBLIC SAFETY-OPERATING	08.145
1576	PUBLIC SAFETY-OPERATING	08.145
1577	PUBLIC SAFETY-OPERATING	08.145
1578	PUBLIC SAFETY-OPERATING	08.145
1579	PUBLIC SAFETY-OPERATING	08.145
1580	PUBLIC SAFETY-OPERATING	08.145
1581	PUBLIC SAFETY-OPERATING	08.155
1582	PUBLIC SAFETY-OPERATING	08.155
1583	PUBLIC SAFETY-OPERATING	08.155
1584	PUBLIC SAFETY-OPERATING	08.155
1585	PUBLIC SAFETY-OPERATING	08.155
1586	PUBLIC SAFETY-OPERATING	08.155
1587	PUBLIC SAFETY-OPERATING	08.155
1588	PUBLIC SAFETY-OPERATING	08.155
1589	PUBLIC SAFETY-OPERATING	08.155
1590	PUBLIC SAFETY-OPERATING	08.160
1591	PUBLIC SAFETY-OPERATING	08.160
1592	PUBLIC SAFETY-OPERATING	08.165
1593	PUBLIC SAFETY-OPERATING	08.165
1594	PUBLIC SAFETY-OPERATING	08.165
1595	PUBLIC SAFETY-OPERATING	08.170
1596	PUBLIC SAFETY-OPERATING	08.170
1597	PUBLIC SAFETY-OPERATING	08.170
1598	PUBLIC SAFETY-OPERATING	08.175
1599	PUBLIC SAFETY-OPERATING	08.180
1600	PUBLIC SAFETY-OPERATING	08.185
1601	PUBLIC SAFETY-OPERATING	08.185
1602	PUBLIC SAFETY-OPERATING	08.185
1603	PUBLIC SAFETY-OPERATING	08.185
1604	PUBLIC SAFETY-OPERATING	08.185
1605	PUBLIC SAFETY-OPERATING	08.185
1606	PUBLIC SAFETY-OPERATING	08.190
1607	PUBLIC SAFETY-OPERATING	08.195
1608	PUBLIC SAFETY-OPERATING	08.195
1609	PUBLIC SAFETY-OPERATING	08.195
1610	PUBLIC SAFETY-OPERATING	08.200
1611	PUBLIC SAFETY-OPERATING	08.200
1612	PUBLIC SAFETY-OPERATING	08.205
1613	PUBLIC SAFETY-OPERATING	08.210
1614	PUBLIC SAFETY-OPERATING	08.215
1615	PUBLIC SAFETY-OPERATING	08.220
1616	PUBLIC SAFETY-OPERATING	08.225
1617	PUBLIC SAFETY-OPERATING	08.230
1618	PUBLIC SAFETY-OPERATING	08.235
1619	PUBLIC SAFETY-OPERATING	08.237
1620	PUBLIC SAFETY-OPERATING	08.240
1621	PUBLIC SAFETY-OPERATING	08.240
1622	PUBLIC SAFETY-OPERATING	08.240
1623	PUBLIC SAFETY-OPERATING	08.240
1624	PUBLIC SAFETY-OPERATING	08.245

Exhibit A

#	Agency	Budget Appropriation Line
1625	PUBLIC SAFETY-OPERATING	08.245
1626	PUBLIC SAFETY-OPERATING	08.245
1627	PUBLIC SAFETY-OPERATING	08.245
1628	PUBLIC SAFETY-OPERATING	08.250
1629	PUBLIC SAFETY-OPERATING	08.250
1630	PUBLIC SAFETY-OPERATING	08.255
1631	PUBLIC SAFETY-OPERATING	08.255
1632	PUBLIC SAFETY-OPERATING	08.255
1633	PUBLIC SAFETY-OPERATING	08.255
1634	PUBLIC SAFETY-OPERATING	08.260
1635	PUBLIC SAFETY-OPERATING	08.265
1636	PUBLIC SAFETY-OPERATING	08.265
1637	PUBLIC SAFETY-OPERATING	08.270
1638	PUBLIC SAFETY-OPERATING	08.275
1639	PUBLIC SAFETY-OPERATING	08.275
1640	PUBLIC SAFETY-OPERATING	08.275
1641	PUBLIC SAFETY-OPERATING	08.275
1642	PUBLIC SAFETY-OPERATING	08.275
1643	PUBLIC SAFETY-OPERATING	08.275
1644	PUBLIC SAFETY-OPERATING	08.275
1645	PUBLIC SAFETY-OPERATING	08.280
1646	PUBLIC SAFETY-OPERATING	08.285
1647	PUBLIC SAFETY-OPERATING	08.285
1648	PUBLIC SAFETY-OPERATING	08.285
1649	PUBLIC SAFETY-OPERATING	08.285
1650	PUBLIC SAFETY-OPERATING	08.285
1651	PUBLIC SAFETY-OPERATING	08.285
1652	PUBLIC SAFETY-OPERATING	08.285
1653	PUBLIC SAFETY-OPERATING	08.285
1654	PUBLIC SAFETY-OPERATING	08.285
1655	PUBLIC SAFETY-OPERATING	08.285
1656	PUBLIC SAFETY-OPERATING	08.287
1657	PUBLIC SAFETY-OPERATING	08.290
1658	PUBLIC SAFETY-OPERATING	08.290
1659	PUBLIC SAFETY-OPERATING	08.295
1660	PUBLIC SAFETY-OPERATING	08.295
1661	PUBLIC SAFETY-OPERATING	08.295
1662	PUBLIC SAFETY-OPERATING	08.295
1663	PUBLIC SAFETY-OPERATING	08.300
1664	CORRECTIONS-OPERATING	09.005
1665	CORRECTIONS-OPERATING	09.005
1666	CORRECTIONS-OPERATING	09.005
1667	CORRECTIONS-OPERATING	09.005
1668	CORRECTIONS-OPERATING	09.005
1669	CORRECTIONS-OPERATING	09.005
1670	CORRECTIONS-OPERATING	09.010
1671	CORRECTIONS-OPERATING	09.010
1672	CORRECTIONS-OPERATING	09.015
1673	CORRECTIONS-OPERATING	09.015
1674	CORRECTIONS-OPERATING	09.015
1675	CORRECTIONS-OPERATING	09.020
1676	CORRECTIONS-OPERATING	09.020
1677	CORRECTIONS-OPERATING	09.020
1678	CORRECTIONS-OPERATING	09.025
1679	CORRECTIONS-OPERATING	09.025
1680	CORRECTIONS-OPERATING	09.025
1681	CORRECTIONS-OPERATING	09.030
1682	CORRECTIONS-OPERATING	09.035

Exhibit A

#	Agency	Budget Appropriation Line
1683	CORRECTIONS-OPERATING	09.040
1684	CORRECTIONS-OPERATING	09.040
1685	CORRECTIONS-OPERATING	09.040
1686	CORRECTIONS-OPERATING	09.040
1687	CORRECTIONS-OPERATING	09.045
1688	CORRECTIONS-OPERATING	09.050
1689	CORRECTIONS-OPERATING	09.050
1690	CORRECTIONS-OPERATING	09.055
1691	CORRECTIONS-OPERATING	09.060
1692	CORRECTIONS-OPERATING	09.065
1693	CORRECTIONS-OPERATING	09.070
1694	CORRECTIONS-OPERATING	09.075
1695	CORRECTIONS-OPERATING	09.075
1696	CORRECTIONS-OPERATING	09.075
1697	CORRECTIONS-OPERATING	09.075
1698	CORRECTIONS-OPERATING	09.075
1699	CORRECTIONS-OPERATING	09.075
1700	CORRECTIONS-OPERATING	09.075
1701	CORRECTIONS-OPERATING	09.075
1702	CORRECTIONS-OPERATING	09.075
1703	CORRECTIONS-OPERATING	09.080
1704	CORRECTIONS-OPERATING	09.080
1705	CORRECTIONS-OPERATING	09.085
1706	CORRECTIONS-OPERATING	09.090
1707	CORRECTIONS-OPERATING	09.090
1708	CORRECTIONS-OPERATING	09.095
1709	CORRECTIONS-OPERATING	09.095
1710	CORRECTIONS-OPERATING	09.100
1711	CORRECTIONS-OPERATING	09.100
1712	CORRECTIONS-OPERATING	09.100
1713	CORRECTIONS-OPERATING	09.105
1714	CORRECTIONS-OPERATING	09.105
1715	CORRECTIONS-OPERATING	09.110
1716	CORRECTIONS-OPERATING	09.110
1717	CORRECTIONS-OPERATING	09.115
1718	CORRECTIONS-OPERATING	09.115
1719	CORRECTIONS-OPERATING	09.120
1720	CORRECTIONS-OPERATING	09.120
1721	CORRECTIONS-OPERATING	09.120
1722	CORRECTIONS-OPERATING	09.125
1723	CORRECTIONS-OPERATING	09.125
1724	CORRECTIONS-OPERATING	09.125
1725	CORRECTIONS-OPERATING	09.130
1726	CORRECTIONS-OPERATING	09.130
1727	CORRECTIONS-OPERATING	09.135
1728	CORRECTIONS-OPERATING	09.135
1729	CORRECTIONS-OPERATING	09.140
1730	CORRECTIONS-OPERATING	09.140
1731	CORRECTIONS-OPERATING	09.145
1732	CORRECTIONS-OPERATING	09.145
1733	CORRECTIONS-OPERATING	09.150
1734	CORRECTIONS-OPERATING	09.150
1735	CORRECTIONS-OPERATING	09.150
1736	CORRECTIONS-OPERATING	09.155
1737	CORRECTIONS-OPERATING	09.155
1738	CORRECTIONS-OPERATING	09.160
1739	CORRECTIONS-OPERATING	09.165
1740	CORRECTIONS-OPERATING	09.165

Exhibit A

#	Agency	Budget Appropriation Line
1741	CORRECTIONS-OPERATING	09.170
1742	CORRECTIONS-OPERATING	09.170
1743	CORRECTIONS-OPERATING	09.175
1744	CORRECTIONS-OPERATING	09.175
1745	CORRECTIONS-OPERATING	09.180
1746	CORRECTIONS-OPERATING	09.180
1747	CORRECTIONS-OPERATING	09.185
1748	CORRECTIONS-OPERATING	09.185
1749	CORRECTIONS-OPERATING	09.190
1750	CORRECTIONS-OPERATING	09.190
1751	CORRECTIONS-OPERATING	09.190
1752	CORRECTIONS-OPERATING	09.195
1753	CORRECTIONS-OPERATING	09.195
1754	CORRECTIONS-OPERATING	09.205
1755	CORRECTIONS-OPERATING	09.210
1756	CORRECTIONS-OPERATING	09.210
1757	CORRECTIONS-OPERATING	09.210
1758	CORRECTIONS-OPERATING	09.215
1759	CORRECTIONS-OPERATING	09.220
1760	CORRECTIONS-OPERATING	09.225
1761	CORRECTIONS-OPERATING	09.225
1762	CORRECTIONS-OPERATING	09.230
1763	CORRECTIONS-OPERATING	09.230
1764	CORRECTIONS-OPERATING	09.230
1765	CORRECTIONS-OPERATING	09.230
1766	CORRECTIONS-OPERATING	09.235
1767	CORRECTIONS-OPERATING	09.240
1768	CORRECTIONS-OPERATING	09.240
1769	CORRECTIONS-OPERATING	09.245
1770	CORRECTIONS-OPERATING	09.250
1771	CORRECTIONS-OPERATING	09.255
1772	CORRECTIONS-OPERATING	09.255
1773	CORRECTIONS-OPERATING	09.260
1774	CORRECTIONS-OPERATING	09.260
1775	CORRECTIONS-OPERATING	09.260
1776	CORRECTIONS-OPERATING	09.260
1777	CORRECTIONS-OPERATING	09.265
1778	CORRECTIONS-OPERATING	09.270
1779	MENTAL HEALTH-OPERATING	10.005
1780	MENTAL HEALTH-OPERATING	10.005
1781	MENTAL HEALTH-OPERATING	10.005
1782	MENTAL HEALTH-OPERATING	10.005
1783	MENTAL HEALTH-OPERATING	10.010
1784	MENTAL HEALTH-OPERATING	10.015
1785	MENTAL HEALTH-OPERATING	10.020
1786	MENTAL HEALTH-OPERATING	10.020
1787	MENTAL HEALTH-OPERATING	10.020
1788	MENTAL HEALTH-OPERATING	10.020
1789	MENTAL HEALTH-OPERATING	10.020
1790	MENTAL HEALTH-OPERATING	10.020
1791	MENTAL HEALTH-OPERATING	10.020
1792	MENTAL HEALTH-OPERATING	10.020
1793	MENTAL HEALTH-OPERATING	10.025
1794	MENTAL HEALTH-OPERATING	10.025
1795	MENTAL HEALTH-OPERATING	10.025
1796	MENTAL HEALTH-OPERATING	10.025
1797	MENTAL HEALTH-OPERATING	10.025
1798	MENTAL HEALTH-OPERATING	10.025

Exhibit A

#	Agency	Budget Appropriation Line
1799	MENTAL HEALTH-OPERATING	10.030
1800	MENTAL HEALTH-OPERATING	10.030
1801	MENTAL HEALTH-OPERATING	10.030
1802	MENTAL HEALTH-OPERATING	10.035
1803	MENTAL HEALTH-OPERATING	10.040
1804	MENTAL HEALTH-OPERATING	10.040
1805	MENTAL HEALTH-OPERATING	10.040
1806	MENTAL HEALTH-OPERATING	10.045
1807	MENTAL HEALTH-OPERATING	10.045
1808	MENTAL HEALTH-OPERATING	10.050
1809	MENTAL HEALTH-OPERATING	10.050
1810	MENTAL HEALTH-OPERATING	10.055
1811	MENTAL HEALTH-OPERATING	10.055
1812	MENTAL HEALTH-OPERATING	10.055
1813	MENTAL HEALTH-OPERATING	10.060
1814	MENTAL HEALTH-OPERATING	10.060
1815	MENTAL HEALTH-OPERATING	10.070
1816	MENTAL HEALTH-OPERATING	10.075
1817	MENTAL HEALTH-OPERATING	10.080
1818	MENTAL HEALTH-OPERATING	10.100
1819	MENTAL HEALTH-OPERATING	10.100
1820	MENTAL HEALTH-OPERATING	10.100
1821	MENTAL HEALTH-OPERATING	10.100
1822	MENTAL HEALTH-OPERATING	10.100
1823	MENTAL HEALTH-OPERATING	10.105
1824	MENTAL HEALTH-OPERATING	10.105
1825	MENTAL HEALTH-OPERATING	10.105
1826	MENTAL HEALTH-OPERATING	10.105
1827	MENTAL HEALTH-OPERATING	10.105
1828	MENTAL HEALTH-OPERATING	10.105
1829	MENTAL HEALTH-OPERATING	10.105
1830	MENTAL HEALTH-OPERATING	10.105
1831	MENTAL HEALTH-OPERATING	10.105
1832	MENTAL HEALTH-OPERATING	10.105
1833	MENTAL HEALTH-OPERATING	10.105
1834	MENTAL HEALTH-OPERATING	10.105
1835	MENTAL HEALTH-OPERATING	10.105
1836	MENTAL HEALTH-OPERATING	10.110
1837	MENTAL HEALTH-OPERATING	10.110
1838	MENTAL HEALTH-OPERATING	10.110
1839	MENTAL HEALTH-OPERATING	10.110
1840	MENTAL HEALTH-OPERATING	10.110
1841	MENTAL HEALTH-OPERATING	10.110
1842	MENTAL HEALTH-OPERATING	10.110
1843	MENTAL HEALTH-OPERATING	10.110
1844	MENTAL HEALTH-OPERATING	10.110
1845	MENTAL HEALTH-OPERATING	10.110
1846	MENTAL HEALTH-OPERATING	10.110
1847	MENTAL HEALTH-OPERATING	10.110
1848	MENTAL HEALTH-OPERATING	10.110
1849	MENTAL HEALTH-OPERATING	10.110
1850	MENTAL HEALTH-OPERATING	10.110
1851	MENTAL HEALTH-OPERATING	10.110
1852	MENTAL HEALTH-OPERATING	10.110
1853	MENTAL HEALTH-OPERATING	10.110
1854	MENTAL HEALTH-OPERATING	10.110
1855	MENTAL HEALTH-OPERATING	10.113
1856	MENTAL HEALTH-OPERATING	10.113

Exhibit A

#	Agency	Budget Appropriation Line
1857	MENTAL HEALTH-OPERATING	10.113
1858	MENTAL HEALTH-OPERATING	10.113
1859	MENTAL HEALTH-OPERATING	10.115
1860	MENTAL HEALTH-OPERATING	10.115
1861	MENTAL HEALTH-OPERATING	10.115
1862	MENTAL HEALTH-OPERATING	10.115
1863	MENTAL HEALTH-OPERATING	10.115
1864	MENTAL HEALTH-OPERATING	10.200
1865	MENTAL HEALTH-OPERATING	10.200
1866	MENTAL HEALTH-OPERATING	10.200
1867	MENTAL HEALTH-OPERATING	10.200
1868	MENTAL HEALTH-OPERATING	10.200
1869	MENTAL HEALTH-OPERATING	10.200
1870	MENTAL HEALTH-OPERATING	10.200
1871	MENTAL HEALTH-OPERATING	10.205
1872	MENTAL HEALTH-OPERATING	10.205
1873	MENTAL HEALTH-OPERATING	10.205
1874	MENTAL HEALTH-OPERATING	10.205
1875	MENTAL HEALTH-OPERATING	10.205
1876	MENTAL HEALTH-OPERATING	10.205
1877	MENTAL HEALTH-OPERATING	10.205
1878	MENTAL HEALTH-OPERATING	10.210
1879	MENTAL HEALTH-OPERATING	10.210
1880	MENTAL HEALTH-OPERATING	10.210
1881	MENTAL HEALTH-OPERATING	10.210
1882	MENTAL HEALTH-OPERATING	10.210
1883	MENTAL HEALTH-OPERATING	10.210
1884	MENTAL HEALTH-OPERATING	10.210
1885	MENTAL HEALTH-OPERATING	10.210
1886	MENTAL HEALTH-OPERATING	10.210
1887	MENTAL HEALTH-OPERATING	10.210
1888	MENTAL HEALTH-OPERATING	10.210
1889	MENTAL HEALTH-OPERATING	10.210
1890	MENTAL HEALTH-OPERATING	10.210
1891	MENTAL HEALTH-OPERATING	10.210
1892	MENTAL HEALTH-OPERATING	10.210
1893	MENTAL HEALTH-OPERATING	10.215
1894	MENTAL HEALTH-OPERATING	10.215
1895	MENTAL HEALTH-OPERATING	10.220
1896	MENTAL HEALTH-OPERATING	10.220
1897	MENTAL HEALTH-OPERATING	10.220
1898	MENTAL HEALTH-OPERATING	10.220
1899	MENTAL HEALTH-OPERATING	10.225
1900	MENTAL HEALTH-OPERATING	10.225
1901	MENTAL HEALTH-OPERATING	10.225
1902	MENTAL HEALTH-OPERATING	10.225
1903	MENTAL HEALTH-OPERATING	10.225
1904	MENTAL HEALTH-OPERATING	10.225
1905	MENTAL HEALTH-OPERATING	10.225
1906	MENTAL HEALTH-OPERATING	10.225
1907	MENTAL HEALTH-OPERATING	10.230
1908	MENTAL HEALTH-OPERATING	10.235
1909	MENTAL HEALTH-OPERATING	10.235
1910	MENTAL HEALTH-OPERATING	10.300
1911	MENTAL HEALTH-OPERATING	10.300
1912	MENTAL HEALTH-OPERATING	10.300
1913	MENTAL HEALTH-OPERATING	10.300
1914	MENTAL HEALTH-OPERATING	10.300

Exhibit A

#	Agency	Budget Appropriation Line
1915	MENTAL HEALTH-OPERATING	10.300
1916	MENTAL HEALTH-OPERATING	10.300
1917	MENTAL HEALTH-OPERATING	10.300
1918	MENTAL HEALTH-OPERATING	10.300
1919	MENTAL HEALTH-OPERATING	10.305
1920	MENTAL HEALTH-OPERATING	10.305
1921	MENTAL HEALTH-OPERATING	10.305
1922	MENTAL HEALTH-OPERATING	10.305
1923	MENTAL HEALTH-OPERATING	10.305
1924	MENTAL HEALTH-OPERATING	10.305
1925	MENTAL HEALTH-OPERATING	10.310
1926	MENTAL HEALTH-OPERATING	10.310
1927	MENTAL HEALTH-OPERATING	10.310
1928	MENTAL HEALTH-OPERATING	10.310
1929	MENTAL HEALTH-OPERATING	10.310
1930	MENTAL HEALTH-OPERATING	10.310
1931	MENTAL HEALTH-OPERATING	10.315
1932	MENTAL HEALTH-OPERATING	10.320
1933	MENTAL HEALTH-OPERATING	10.320
1934	MENTAL HEALTH-OPERATING	10.320
1935	MENTAL HEALTH-OPERATING	10.320
1936	MENTAL HEALTH-OPERATING	10.320
1937	MENTAL HEALTH-OPERATING	10.325
1938	MENTAL HEALTH-OPERATING	10.325
1939	MENTAL HEALTH-OPERATING	10.325
1940	MENTAL HEALTH-OPERATING	10.325
1941	MENTAL HEALTH-OPERATING	10.325
1942	MENTAL HEALTH-OPERATING	10.325
1943	MENTAL HEALTH-OPERATING	10.325
1944	MENTAL HEALTH-OPERATING	10.325
1945	MENTAL HEALTH-OPERATING	10.325
1946	MENTAL HEALTH-OPERATING	10.330
1947	MENTAL HEALTH-OPERATING	10.330
1948	MENTAL HEALTH-OPERATING	10.330
1949	MENTAL HEALTH-OPERATING	10.330
1950	MENTAL HEALTH-OPERATING	10.330
1951	MENTAL HEALTH-OPERATING	10.330
1952	MENTAL HEALTH-OPERATING	10.335
1953	MENTAL HEALTH-OPERATING	10.335
1954	MENTAL HEALTH-OPERATING	10.335
1955	MENTAL HEALTH-OPERATING	10.335
1956	MENTAL HEALTH-OPERATING	10.335
1957	MENTAL HEALTH-OPERATING	10.335
1958	MENTAL HEALTH-OPERATING	10.335
1959	MENTAL HEALTH-OPERATING	10.400
1960	MENTAL HEALTH-OPERATING	10.400
1961	MENTAL HEALTH-OPERATING	10.400
1962	MENTAL HEALTH-OPERATING	10.400
1963	MENTAL HEALTH-OPERATING	10.405
1964	MENTAL HEALTH-OPERATING	10.410
1965	MENTAL HEALTH-OPERATING	10.410
1966	MENTAL HEALTH-OPERATING	10.410
1967	MENTAL HEALTH-OPERATING	10.410
1968	MENTAL HEALTH-OPERATING	10.410
1969	MENTAL HEALTH-OPERATING	10.410
1970	MENTAL HEALTH-OPERATING	10.410
1971	MENTAL HEALTH-OPERATING	10.410
1972	MENTAL HEALTH-OPERATING	10.410

Exhibit A

#	Agency	Budget Appropriation Line
1973	MENTAL HEALTH-OPERATING	10.410
1974	MENTAL HEALTH-OPERATING	10.410
1975	MENTAL HEALTH-OPERATING	10.410
1976	MENTAL HEALTH-OPERATING	10.410
1977	MENTAL HEALTH-OPERATING	10.410
1978	MENTAL HEALTH-OPERATING	10.410
1979	MENTAL HEALTH-OPERATING	10.410
1980	MENTAL HEALTH-OPERATING	10.415
1981	MENTAL HEALTH-OPERATING	10.415
1982	MENTAL HEALTH-OPERATING	10.420
1983	MENTAL HEALTH-OPERATING	10.420
1984	MENTAL HEALTH-OPERATING	10.425
1985	MENTAL HEALTH-OPERATING	10.425
1986	MENTAL HEALTH-OPERATING	10.500
1987	MENTAL HEALTH-OPERATING	10.500
1988	MENTAL HEALTH-OPERATING	10.500
1989	MENTAL HEALTH-OPERATING	10.500
1990	MENTAL HEALTH-OPERATING	10.500
1991	MENTAL HEALTH-OPERATING	10.505
1992	MENTAL HEALTH-OPERATING	10.505
1993	MENTAL HEALTH-OPERATING	10.505
1994	MENTAL HEALTH-OPERATING	10.505
1995	MENTAL HEALTH-OPERATING	10.505
1996	MENTAL HEALTH-OPERATING	10.510
1997	MENTAL HEALTH-OPERATING	10.510
1998	MENTAL HEALTH-OPERATING	10.510
1999	MENTAL HEALTH-OPERATING	10.510
2000	MENTAL HEALTH-OPERATING	10.510
2001	MENTAL HEALTH-OPERATING	10.515
2002	MENTAL HEALTH-OPERATING	10.515
2003	MENTAL HEALTH-OPERATING	10.515
2004	MENTAL HEALTH-OPERATING	10.515
2005	MENTAL HEALTH-OPERATING	10.515
2006	MENTAL HEALTH-OPERATING	10.520
2007	MENTAL HEALTH-OPERATING	10.520
2008	MENTAL HEALTH-OPERATING	10.520
2009	MENTAL HEALTH-OPERATING	10.520
2010	MENTAL HEALTH-OPERATING	10.520
2011	MENTAL HEALTH-OPERATING	10.525
2012	MENTAL HEALTH-OPERATING	10.525
2013	MENTAL HEALTH-OPERATING	10.525
2014	MENTAL HEALTH-OPERATING	10.525
2015	MENTAL HEALTH-OPERATING	10.525
2016	MENTAL HEALTH-OPERATING	10.525
2017	MENTAL HEALTH-OPERATING	10.530
2018	MENTAL HEALTH-OPERATING	10.530
2019	MENTAL HEALTH-OPERATING	10.530
2020	MENTAL HEALTH-OPERATING	10.530
2021	MENTAL HEALTH-OPERATING	10.530
2022	MENTAL HEALTH-OPERATING	10.530
2023	MENTAL HEALTH-OPERATING	10.535
2024	MENTAL HEALTH-OPERATING	10.535
2025	MENTAL HEALTH-OPERATING	10.535
2026	MENTAL HEALTH-OPERATING	10.535
2027	MENTAL HEALTH-OPERATING	10.535
2028	MENTAL HEALTH-OPERATING	10.540
2029	MENTAL HEALTH-OPERATING	10.540
2030	MENTAL HEALTH-OPERATING	10.540

Exhibit A

#	Agency	Budget Appropriation Line
2031	MENTAL HEALTH-OPERATING	10.540
2032	MENTAL HEALTH-OPERATING	10.540
2033	MENTAL HEALTH-OPERATING	10.540
2034	MENTAL HEALTH-OPERATING	10.545
2035	MENTAL HEALTH-OPERATING	10.545
2036	MENTAL HEALTH-OPERATING	10.545
2037	MENTAL HEALTH-OPERATING	10.545
2038	MENTAL HEALTH-OPERATING	10.545
2039	MENTAL HEALTH-OPERATING	10.550
2040	MENTAL HEALTH-OPERATING	10.550
2041	MENTAL HEALTH-OPERATING	10.550
2042	MENTAL HEALTH-OPERATING	10.550
2043	MENTAL HEALTH-OPERATING	10.550
2044	MENTAL HEALTH-OPERATING	10.550
2045	MENTAL HEALTH-OPERATING	10.575
2046	HEALTH & SENIOR SERVICES-OPER	10.600
2047	HEALTH & SENIOR SERVICES-OPER	10.600
2048	HEALTH & SENIOR SERVICES-OPER	10.600
2049	HEALTH & SENIOR SERVICES-OPER	10.600
2050	HEALTH & SENIOR SERVICES-OPER	10.605
2051	HEALTH & SENIOR SERVICES-OPER	10.605
2052	HEALTH & SENIOR SERVICES-OPER	10.605
2053	HEALTH & SENIOR SERVICES-OPER	10.605
2054	HEALTH & SENIOR SERVICES-OPER	10.605
2055	HEALTH & SENIOR SERVICES-OPER	10.605
2056	HEALTH & SENIOR SERVICES-OPER	10.605
2057	HEALTH & SENIOR SERVICES-OPER	10.605
2058	HEALTH & SENIOR SERVICES-OPER	10.605
2059	HEALTH & SENIOR SERVICES-OPER	10.605
2060	HEALTH & SENIOR SERVICES-OPER	10.605
2061	HEALTH & SENIOR SERVICES-OPER	10.605
2062	HEALTH & SENIOR SERVICES-OPER	10.605
2063	HEALTH & SENIOR SERVICES-OPER	10.605
2064	HEALTH & SENIOR SERVICES-OPER	10.605
2065	HEALTH & SENIOR SERVICES-OPER	10.605
2066	HEALTH & SENIOR SERVICES-OPER	10.605
2067	HEALTH & SENIOR SERVICES-OPER	10.610
2068	HEALTH & SENIOR SERVICES-OPER	10.615
2069	HEALTH & SENIOR SERVICES-OPER	10.620
2070	HEALTH & SENIOR SERVICES-OPER	10.620
2071	HEALTH & SENIOR SERVICES-OPER	10.625
2072	HEALTH & SENIOR SERVICES-OPER	10.625
2073	HEALTH & SENIOR SERVICES-OPER	10.625
2074	HEALTH & SENIOR SERVICES-OPER	10.625
2075	HEALTH & SENIOR SERVICES-OPER	10.700
2076	HEALTH & SENIOR SERVICES-OPER	10.700
2077	HEALTH & SENIOR SERVICES-OPER	10.700
2078	HEALTH & SENIOR SERVICES-OPER	10.700
2079	HEALTH & SENIOR SERVICES-OPER	10.700
2080	HEALTH & SENIOR SERVICES-OPER	10.700
2081	HEALTH & SENIOR SERVICES-OPER	10.700
2082	HEALTH & SENIOR SERVICES-OPER	10.700
2083	HEALTH & SENIOR SERVICES-OPER	10.700
2084	HEALTH & SENIOR SERVICES-OPER	10.700
2085	HEALTH & SENIOR SERVICES-OPER	10.700
2086	HEALTH & SENIOR SERVICES-OPER	10.700
2087	HEALTH & SENIOR SERVICES-OPER	10.700
2088	HEALTH & SENIOR SERVICES-OPER	10.700

Exhibit A

#	Agency	Budget Appropriation Line
2089	HEALTH & SENIOR SERVICES-OPER	10.700
2090	HEALTH & SENIOR SERVICES-OPER	10.700
2091	HEALTH & SENIOR SERVICES-OPER	10.700
2092	HEALTH & SENIOR SERVICES-OPER	10.700
2093	HEALTH & SENIOR SERVICES-OPER	10.700
2094	HEALTH & SENIOR SERVICES-OPER	10.700
2095	HEALTH & SENIOR SERVICES-OPER	10.700
2096	HEALTH & SENIOR SERVICES-OPER	10.700
2097	HEALTH & SENIOR SERVICES-OPER	10.700
2098	HEALTH & SENIOR SERVICES-OPER	10.700
2099	HEALTH & SENIOR SERVICES-OPER	10.700
2100	HEALTH & SENIOR SERVICES-OPER	10.700
2101	HEALTH & SENIOR SERVICES-OPER	10.700
2102	HEALTH & SENIOR SERVICES-OPER	10.700
2103	HEALTH & SENIOR SERVICES-OPER	10.705
2104	HEALTH & SENIOR SERVICES-OPER	10.705
2105	HEALTH & SENIOR SERVICES-OPER	10.710
2106	HEALTH & SENIOR SERVICES-OPER	10.710
2107	HEALTH & SENIOR SERVICES-OPER	10.710
2108	HEALTH & SENIOR SERVICES-OPER	10.710
2109	HEALTH & SENIOR SERVICES-OPER	10.710
2110	HEALTH & SENIOR SERVICES-OPER	10.710
2111	HEALTH & SENIOR SERVICES-OPER	10.710
2112	HEALTH & SENIOR SERVICES-OPER	10.710
2113	HEALTH & SENIOR SERVICES-OPER	10.710
2114	HEALTH & SENIOR SERVICES-OPER	10.710
2115	HEALTH & SENIOR SERVICES-OPER	10.710
2116	HEALTH & SENIOR SERVICES-OPER	10.710
2117	HEALTH & SENIOR SERVICES-OPER	10.710
2118	HEALTH & SENIOR SERVICES-OPER	10.710
2119	HEALTH & SENIOR SERVICES-OPER	10.710
2120	HEALTH & SENIOR SERVICES-OPER	10.710
2121	HEALTH & SENIOR SERVICES-OPER	10.710
2122	HEALTH & SENIOR SERVICES-OPER	10.710
2123	HEALTH & SENIOR SERVICES-OPER	10.710
2124	HEALTH & SENIOR SERVICES-OPER	10.710
2125	HEALTH & SENIOR SERVICES-OPER	10.710
2126	HEALTH & SENIOR SERVICES-OPER	10.710
2127	HEALTH & SENIOR SERVICES-OPER	10.715
2128	HEALTH & SENIOR SERVICES-OPER	10.715
2129	HEALTH & SENIOR SERVICES-OPER	10.715
2130	HEALTH & SENIOR SERVICES-OPER	10.715
2131	HEALTH & SENIOR SERVICES-OPER	10.715
2132	HEALTH & SENIOR SERVICES-OPER	10.715
2133	HEALTH & SENIOR SERVICES-OPER	10.718
2134	HEALTH & SENIOR SERVICES-OPER	10.718
2135	HEALTH & SENIOR SERVICES-OPER	10.720
2136	HEALTH & SENIOR SERVICES-OPER	10.723
2137	HEALTH & SENIOR SERVICES-OPER	10.725
2138	HEALTH & SENIOR SERVICES-OPER	10.725
2139	HEALTH & SENIOR SERVICES-OPER	10.725
2140	HEALTH & SENIOR SERVICES-OPER	10.730
2141	HEALTH & SENIOR SERVICES-OPER	10.730
2142	HEALTH & SENIOR SERVICES-OPER	10.730
2143	HEALTH & SENIOR SERVICES-OPER	10.730
2144	HEALTH & SENIOR SERVICES-OPER	10.730
2145	HEALTH & SENIOR SERVICES-OPER	10.730
2146	HEALTH & SENIOR SERVICES-OPER	10.730

Exhibit A

#	Agency	Budget Appropriation Line
2147	HEALTH & SENIOR SERVICES-OPER	10.730
2148	HEALTH & SENIOR SERVICES-OPER	10.730
2149	HEALTH & SENIOR SERVICES-OPER	10.730
2150	HEALTH & SENIOR SERVICES-OPER	10.730
2151	HEALTH & SENIOR SERVICES-OPER	10.730
2152	HEALTH & SENIOR SERVICES-OPER	10.735
2153	HEALTH & SENIOR SERVICES-OPER	10.735
2154	HEALTH & SENIOR SERVICES-OPER	10.735
2155	HEALTH & SENIOR SERVICES-OPER	10.735
2156	HEALTH & SENIOR SERVICES-OPER	10.735
2157	HEALTH & SENIOR SERVICES-OPER	10.740
2158	HEALTH & SENIOR SERVICES-OPER	10.740
2159	HEALTH & SENIOR SERVICES-OPER	10.740
2160	HEALTH & SENIOR SERVICES-OPER	10.745
2161	HEALTH & SENIOR SERVICES-OPER	10.745
2162	HEALTH & SENIOR SERVICES-OPER	10.745
2163	HEALTH & SENIOR SERVICES-OPER	10.750
2164	HEALTH & SENIOR SERVICES-OPER	10.750
2165	HEALTH & SENIOR SERVICES-OPER	10.750
2166	HEALTH & SENIOR SERVICES-OPER	10.750
2167	HEALTH & SENIOR SERVICES-OPER	10.750
2168	HEALTH & SENIOR SERVICES-OPER	10.750
2169	HEALTH & SENIOR SERVICES-OPER	10.750
2170	HEALTH & SENIOR SERVICES-OPER	10.750
2171	HEALTH & SENIOR SERVICES-OPER	10.750
2172	HEALTH & SENIOR SERVICES-OPER	10.750
2173	HEALTH & SENIOR SERVICES-OPER	10.750
2174	HEALTH & SENIOR SERVICES-OPER	10.750
2175	HEALTH & SENIOR SERVICES-OPER	10.750
2176	HEALTH & SENIOR SERVICES-OPER	10.800
2177	HEALTH & SENIOR SERVICES-OPER	10.800
2178	HEALTH & SENIOR SERVICES-OPER	10.800
2179	HEALTH & SENIOR SERVICES-OPER	10.800
2180	HEALTH & SENIOR SERVICES-OPER	10.800
2181	HEALTH & SENIOR SERVICES-OPER	10.800
2182	HEALTH & SENIOR SERVICES-OPER	10.800
2183	HEALTH & SENIOR SERVICES-OPER	10.800
2184	HEALTH & SENIOR SERVICES-OPER	10.800
2185	HEALTH & SENIOR SERVICES-OPER	10.800
2186	HEALTH & SENIOR SERVICES-OPER	10.800
2187	HEALTH & SENIOR SERVICES-OPER	10.800
2188	HEALTH & SENIOR SERVICES-OPER	10.805
2189	HEALTH & SENIOR SERVICES-OPER	10.805
2190	HEALTH & SENIOR SERVICES-OPER	10.805
2191	HEALTH & SENIOR SERVICES-OPER	10.806
2192	HEALTH & SENIOR SERVICES-OPER	10.810
2193	HEALTH & SENIOR SERVICES-OPER	10.815
2194	HEALTH & SENIOR SERVICES-OPER	10.815
2195	HEALTH & SENIOR SERVICES-OPER	10.815
2196	HEALTH & SENIOR SERVICES-OPER	10.815
2197	HEALTH & SENIOR SERVICES-OPER	10.815
2198	HEALTH & SENIOR SERVICES-OPER	10.820
2199	HEALTH & SENIOR SERVICES-OPER	10.820
2200	HEALTH & SENIOR SERVICES-OPER	10.825
2201	HEALTH & SENIOR SERVICES-OPER	10.830
2202	HEALTH & SENIOR SERVICES-OPER	10.900
2203	HEALTH & SENIOR SERVICES-OPER	10.900
2204	HEALTH & SENIOR SERVICES-OPER	10.900

Exhibit A

#	Agency	Budget Appropriation Line
2205	HEALTH & SENIOR SERVICES-OPER	10.900
2206	HEALTH & SENIOR SERVICES-OPER	10.900
2207	HEALTH & SENIOR SERVICES-OPER	10.900
2208	HEALTH & SENIOR SERVICES-OPER	10.900
2209	HEALTH & SENIOR SERVICES-OPER	10.900
2210	HEALTH & SENIOR SERVICES-OPER	10.900
2211	HEALTH & SENIOR SERVICES-OPER	10.900
2212	HEALTH & SENIOR SERVICES-OPER	10.900
2213	HEALTH & SENIOR SERVICES-OPER	10.900
2214	HEALTH & SENIOR SERVICES-OPER	10.900
2215	HEALTH & SENIOR SERVICES-OPER	10.900
2216	HEALTH & SENIOR SERVICES-OPER	10.900
2217	HEALTH & SENIOR SERVICES-OPER	10.900
2218	HEALTH & SENIOR SERVICES-OPER	10.900
2219	HEALTH & SENIOR SERVICES-OPER	10.900
2220	HEALTH & SENIOR SERVICES-OPER	10.900
2221	HEALTH & SENIOR SERVICES-OPER	10.900
2222	HEALTH & SENIOR SERVICES-OPER	10.900
2223	HEALTH & SENIOR SERVICES-OPER	10.900
2224	HEALTH & SENIOR SERVICES-OPER	10.905
2225	HEALTH & SENIOR SERVICES-OPER	10.955
2226	SOCIAL SERVICES-OPERATING	11.005
2227	SOCIAL SERVICES-OPERATING	11.005
2228	SOCIAL SERVICES-OPERATING	11.005
2229	SOCIAL SERVICES-OPERATING	11.005
2230	SOCIAL SERVICES-OPERATING	11.005
2231	SOCIAL SERVICES-OPERATING	11.010
2232	SOCIAL SERVICES-OPERATING	11.010
2233	SOCIAL SERVICES-OPERATING	11.015
2234	SOCIAL SERVICES-OPERATING	11.015
2235	SOCIAL SERVICES-OPERATING	11.015
2236	SOCIAL SERVICES-OPERATING	11.015
2237	SOCIAL SERVICES-OPERATING	11.020
2238	SOCIAL SERVICES-OPERATING	11.020
2239	SOCIAL SERVICES-OPERATING	11.020
2240	SOCIAL SERVICES-OPERATING	11.020
2241	SOCIAL SERVICES-OPERATING	11.020
2242	SOCIAL SERVICES-OPERATING	11.020
2243	SOCIAL SERVICES-OPERATING	11.020
2244	SOCIAL SERVICES-OPERATING	11.025
2245	SOCIAL SERVICES-OPERATING	11.025
2246	SOCIAL SERVICES-OPERATING	11.030
2247	SOCIAL SERVICES-OPERATING	11.035
2248	SOCIAL SERVICES-OPERATING	11.035
2249	SOCIAL SERVICES-OPERATING	11.035
2250	SOCIAL SERVICES-OPERATING	11.035
2251	SOCIAL SERVICES-OPERATING	11.035
2252	SOCIAL SERVICES-OPERATING	11.035
2253	SOCIAL SERVICES-OPERATING	11.035
2254	SOCIAL SERVICES-OPERATING	11.035
2255	SOCIAL SERVICES-OPERATING	11.040
2256	SOCIAL SERVICES-OPERATING	11.045
2257	SOCIAL SERVICES-OPERATING	11.045
2258	SOCIAL SERVICES-OPERATING	11.045
2259	SOCIAL SERVICES-OPERATING	11.045
2260	SOCIAL SERVICES-OPERATING	11.045
2261	SOCIAL SERVICES-OPERATING	11.045
2262	SOCIAL SERVICES-OPERATING	11.045

Exhibit A

#	Agency	Budget Appropriation Line
2263	SOCIAL SERVICES-OPERATING	11.050
2264	SOCIAL SERVICES-OPERATING	11.055
2265	SOCIAL SERVICES-OPERATING	11.055
2266	SOCIAL SERVICES-OPERATING	11.055
2267	SOCIAL SERVICES-OPERATING	11.055
2268	SOCIAL SERVICES-OPERATING	11.055
2269	SOCIAL SERVICES-OPERATING	11.055
2270	SOCIAL SERVICES-OPERATING	11.055
2271	SOCIAL SERVICES-OPERATING	11.060
2272	SOCIAL SERVICES-OPERATING	11.060
2273	SOCIAL SERVICES-OPERATING	11.060
2274	SOCIAL SERVICES-OPERATING	11.060
2275	SOCIAL SERVICES-OPERATING	11.060
2276	SOCIAL SERVICES-OPERATING	11.060
2277	SOCIAL SERVICES-OPERATING	11.060
2278	SOCIAL SERVICES-OPERATING	11.065
2279	SOCIAL SERVICES-OPERATING	11.065
2280	SOCIAL SERVICES-OPERATING	11.065
2281	SOCIAL SERVICES-OPERATING	11.065
2282	SOCIAL SERVICES-OPERATING	11.065
2283	SOCIAL SERVICES-OPERATING	11.065
2284	SOCIAL SERVICES-OPERATING	11.065
2285	SOCIAL SERVICES-OPERATING	11.065
2286	SOCIAL SERVICES-OPERATING	11.070
2287	SOCIAL SERVICES-OPERATING	11.070
2288	SOCIAL SERVICES-OPERATING	11.075
2289	SOCIAL SERVICES-OPERATING	11.075
2290	SOCIAL SERVICES-OPERATING	11.080
2291	SOCIAL SERVICES-OPERATING	11.085
2292	SOCIAL SERVICES-OPERATING	11.085
2293	SOCIAL SERVICES-OPERATING	11.085
2294	SOCIAL SERVICES-OPERATING	11.090
2295	SOCIAL SERVICES-OPERATING	11.090
2296	SOCIAL SERVICES-OPERATING	11.090
2297	SOCIAL SERVICES-OPERATING	11.095
2298	SOCIAL SERVICES-OPERATING	11.095
2299	SOCIAL SERVICES-OPERATING	11.095
2300	SOCIAL SERVICES-OPERATING	11.095
2301	SOCIAL SERVICES-OPERATING	11.095
2302	SOCIAL SERVICES-OPERATING	11.095
2303	SOCIAL SERVICES-OPERATING	11.095
2304	SOCIAL SERVICES-OPERATING	11.100
2305	SOCIAL SERVICES-OPERATING	11.100
2306	SOCIAL SERVICES-OPERATING	11.105
2307	SOCIAL SERVICES-OPERATING	11.110
2308	SOCIAL SERVICES-OPERATING	11.110
2309	SOCIAL SERVICES-OPERATING	11.110
2310	SOCIAL SERVICES-OPERATING	11.110
2311	SOCIAL SERVICES-OPERATING	11.110
2312	SOCIAL SERVICES-OPERATING	11.110
2313	SOCIAL SERVICES-OPERATING	11.110
2314	SOCIAL SERVICES-OPERATING	11.110
2315	SOCIAL SERVICES-OPERATING	11.110
2316	SOCIAL SERVICES-OPERATING	11.110
2317	SOCIAL SERVICES-OPERATING	11.110
2318	SOCIAL SERVICES-OPERATING	11.110
2319	SOCIAL SERVICES-OPERATING	11.115
2320	SOCIAL SERVICES-OPERATING	11.115

Exhibit A

#	Agency	Budget Appropriation Line
2321	SOCIAL SERVICES-OPERATING	11.115
2322	SOCIAL SERVICES-OPERATING	11.115
2323	SOCIAL SERVICES-OPERATING	11.115
2324	SOCIAL SERVICES-OPERATING	11.125
2325	SOCIAL SERVICES-OPERATING	11.130
2326	SOCIAL SERVICES-OPERATING	11.130
2327	SOCIAL SERVICES-OPERATING	11.135
2328	SOCIAL SERVICES-OPERATING	11.140
2329	SOCIAL SERVICES-OPERATING	11.145
2330	SOCIAL SERVICES-OPERATING	11.150
2331	SOCIAL SERVICES-OPERATING	11.155
2332	SOCIAL SERVICES-OPERATING	11.155
2333	SOCIAL SERVICES-OPERATING	11.155
2334	SOCIAL SERVICES-OPERATING	11.160
2335	SOCIAL SERVICES-OPERATING	11.160
2336	SOCIAL SERVICES-OPERATING	11.160
2337	SOCIAL SERVICES-OPERATING	11.160
2338	SOCIAL SERVICES-OPERATING	11.165
2339	SOCIAL SERVICES-OPERATING	11.165
2340	SOCIAL SERVICES-OPERATING	11.165
2341	SOCIAL SERVICES-OPERATING	11.170
2342	SOCIAL SERVICES-OPERATING	11.170
2343	SOCIAL SERVICES-OPERATING	11.175
2344	SOCIAL SERVICES-OPERATING	11.175
2345	SOCIAL SERVICES-OPERATING	11.175
2346	SOCIAL SERVICES-OPERATING	11.175
2347	SOCIAL SERVICES-OPERATING	11.180
2348	SOCIAL SERVICES-OPERATING	11.180
2349	SOCIAL SERVICES-OPERATING	11.180
2350	SOCIAL SERVICES-OPERATING	11.180
2351	SOCIAL SERVICES-OPERATING	11.185
2352	SOCIAL SERVICES-OPERATING	11.190
2353	SOCIAL SERVICES-OPERATING	11.190
2354	SOCIAL SERVICES-OPERATING	11.190
2355	SOCIAL SERVICES-OPERATING	11.190
2356	SOCIAL SERVICES-OPERATING	11.190
2357	SOCIAL SERVICES-OPERATING	11.190
2358	SOCIAL SERVICES-OPERATING	11.190
2359	SOCIAL SERVICES-OPERATING	11.195
2360	SOCIAL SERVICES-OPERATING	11.195
2361	SOCIAL SERVICES-OPERATING	11.195
2362	SOCIAL SERVICES-OPERATING	11.200
2363	SOCIAL SERVICES-OPERATING	11.200
2364	SOCIAL SERVICES-OPERATING	11.205
2365	SOCIAL SERVICES-OPERATING	11.205
2366	SOCIAL SERVICES-OPERATING	11.210
2367	SOCIAL SERVICES-OPERATING	11.210
2368	SOCIAL SERVICES-OPERATING	11.210
2369	SOCIAL SERVICES-OPERATING	11.210
2370	SOCIAL SERVICES-OPERATING	11.210
2371	SOCIAL SERVICES-OPERATING	11.210
2372	SOCIAL SERVICES-OPERATING	11.210
2373	SOCIAL SERVICES-OPERATING	11.215
2374	SOCIAL SERVICES-OPERATING	11.215
2375	SOCIAL SERVICES-OPERATING	11.215
2376	SOCIAL SERVICES-OPERATING	11.215
2377	SOCIAL SERVICES-OPERATING	11.215
2378	SOCIAL SERVICES-OPERATING	11.215

Exhibit A

#	Agency	Budget Appropriation Line
2379	SOCIAL SERVICES-OPERATING	11.215
2380	SOCIAL SERVICES-OPERATING	11.215
2381	SOCIAL SERVICES-OPERATING	11.220
2382	SOCIAL SERVICES-OPERATING	11.220
2383	SOCIAL SERVICES-OPERATING	11.225
2384	SOCIAL SERVICES-OPERATING	11.225
2385	SOCIAL SERVICES-OPERATING	11.225
2386	SOCIAL SERVICES-OPERATING	11.225
2387	SOCIAL SERVICES-OPERATING	11.225
2388	SOCIAL SERVICES-OPERATING	11.230
2389	SOCIAL SERVICES-OPERATING	11.230
2390	SOCIAL SERVICES-OPERATING	11.235
2391	SOCIAL SERVICES-OPERATING	11.235
2392	SOCIAL SERVICES-OPERATING	11.235
2393	SOCIAL SERVICES-OPERATING	11.235
2394	SOCIAL SERVICES-OPERATING	11.235
2395	SOCIAL SERVICES-OPERATING	11.235
2396	SOCIAL SERVICES-OPERATING	11.240
2397	SOCIAL SERVICES-OPERATING	11.245
2398	SOCIAL SERVICES-OPERATING	11.245
2399	SOCIAL SERVICES-OPERATING	11.245
2400	SOCIAL SERVICES-OPERATING	11.250
2401	SOCIAL SERVICES-OPERATING	11.250
2402	SOCIAL SERVICES-OPERATING	11.255
2403	SOCIAL SERVICES-OPERATING	11.255
2404	SOCIAL SERVICES-OPERATING	11.260
2405	SOCIAL SERVICES-OPERATING	11.260
2406	SOCIAL SERVICES-OPERATING	11.260
2407	SOCIAL SERVICES-OPERATING	11.260
2408	SOCIAL SERVICES-OPERATING	11.260
2409	SOCIAL SERVICES-OPERATING	11.260
2410	SOCIAL SERVICES-OPERATING	11.265
2411	SOCIAL SERVICES-OPERATING	11.265
2412	SOCIAL SERVICES-OPERATING	11.270
2413	SOCIAL SERVICES-OPERATING	11.270
2414	SOCIAL SERVICES-OPERATING	11.270
2415	SOCIAL SERVICES-OPERATING	11.275
2416	SOCIAL SERVICES-OPERATING	11.280
2417	SOCIAL SERVICES-OPERATING	11.285
2418	SOCIAL SERVICES-OPERATING	11.290
2419	SOCIAL SERVICES-OPERATING	11.295
2420	SOCIAL SERVICES-OPERATING	11.295
2421	SOCIAL SERVICES-OPERATING	11.295
2422	SOCIAL SERVICES-OPERATING	11.295
2423	SOCIAL SERVICES-OPERATING	11.295
2424	SOCIAL SERVICES-OPERATING	11.295
2425	SOCIAL SERVICES-OPERATING	11.295
2426	SOCIAL SERVICES-OPERATING	11.295
2427	SOCIAL SERVICES-OPERATING	11.295
2428	SOCIAL SERVICES-OPERATING	11.300
2429	SOCIAL SERVICES-OPERATING	11.300
2430	SOCIAL SERVICES-OPERATING	11.300
2431	SOCIAL SERVICES-OPERATING	11.300
2432	SOCIAL SERVICES-OPERATING	11.300
2433	SOCIAL SERVICES-OPERATING	11.305
2434	SOCIAL SERVICES-OPERATING	11.305
2435	SOCIAL SERVICES-OPERATING	11.305
2436	SOCIAL SERVICES-OPERATING	11.305

Exhibit A

#	Agency	Budget Appropriation Line
2437	SOCIAL SERVICES-OPERATING	11.305
2438	SOCIAL SERVICES-OPERATING	11.305
2439	SOCIAL SERVICES-OPERATING	11.305
2440	SOCIAL SERVICES-OPERATING	11.305
2441	SOCIAL SERVICES-OPERATING	11.305
2442	SOCIAL SERVICES-OPERATING	11.305
2443	SOCIAL SERVICES-OPERATING	11.305
2444	SOCIAL SERVICES-OPERATING	11.310
2445	SOCIAL SERVICES-OPERATING	11.310
2446	SOCIAL SERVICES-OPERATING	11.400
2447	SOCIAL SERVICES-OPERATING	11.400
2448	SOCIAL SERVICES-OPERATING	11.400
2449	SOCIAL SERVICES-OPERATING	11.400
2450	SOCIAL SERVICES-OPERATING	11.400
2451	SOCIAL SERVICES-OPERATING	11.400
2452	SOCIAL SERVICES-OPERATING	11.400
2453	SOCIAL SERVICES-OPERATING	11.400
2454	SOCIAL SERVICES-OPERATING	11.400
2455	SOCIAL SERVICES-OPERATING	11.400
2456	SOCIAL SERVICES-OPERATING	11.400
2457	SOCIAL SERVICES-OPERATING	11.400
2458	SOCIAL SERVICES-OPERATING	11.400
2459	SOCIAL SERVICES-OPERATING	11.400
2460	SOCIAL SERVICES-OPERATING	11.400
2461	SOCIAL SERVICES-OPERATING	11.400
2462	SOCIAL SERVICES-OPERATING	11.400
2463	SOCIAL SERVICES-OPERATING	11.400
2464	SOCIAL SERVICES-OPERATING	11.400
2465	SOCIAL SERVICES-OPERATING	11.400
2466	SOCIAL SERVICES-OPERATING	11.400
2467	SOCIAL SERVICES-OPERATING	11.405
2468	SOCIAL SERVICES-OPERATING	11.405
2469	SOCIAL SERVICES-OPERATING	11.405
2470	SOCIAL SERVICES-OPERATING	11.405
2471	SOCIAL SERVICES-OPERATING	11.405
2472	SOCIAL SERVICES-OPERATING	11.410
2473	SOCIAL SERVICES-OPERATING	11.410
2474	SOCIAL SERVICES-OPERATING	11.415
2475	SOCIAL SERVICES-OPERATING	11.415
2476	SOCIAL SERVICES-OPERATING	11.420
2477	SOCIAL SERVICES-OPERATING	11.420
2478	SOCIAL SERVICES-OPERATING	11.420
2479	SOCIAL SERVICES-OPERATING	11.420
2480	SOCIAL SERVICES-OPERATING	11.420
2481	SOCIAL SERVICES-OPERATING	11.425
2482	SOCIAL SERVICES-OPERATING	11.430
2483	SOCIAL SERVICES-OPERATING	11.435
2484	SOCIAL SERVICES-OPERATING	11.435
2485	SOCIAL SERVICES-OPERATING	11.435
2486	SOCIAL SERVICES-OPERATING	11.435
2487	SOCIAL SERVICES-OPERATING	11.435
2488	SOCIAL SERVICES-OPERATING	11.435
2489	SOCIAL SERVICES-OPERATING	11.435
2490	SOCIAL SERVICES-OPERATING	11.435
2491	SOCIAL SERVICES-OPERATING	11.435
2492	SOCIAL SERVICES-OPERATING	11.436
2493	SOCIAL SERVICES-OPERATING	11.436
2494	SOCIAL SERVICES-OPERATING	11.440

Exhibit A

#	Agency	Budget Appropriation Line
2495	SOCIAL SERVICES-OPERATING	11.450
2496	SOCIAL SERVICES-OPERATING	11.455
2497	SOCIAL SERVICES-OPERATING	11.455
2498	SOCIAL SERVICES-OPERATING	11.455
2499	SOCIAL SERVICES-OPERATING	11.455
2500	SOCIAL SERVICES-OPERATING	11.455
2501	SOCIAL SERVICES-OPERATING	11.455
2502	SOCIAL SERVICES-OPERATING	11.455
2503	SOCIAL SERVICES-OPERATING	11.455
2504	SOCIAL SERVICES-OPERATING	11.455
2505	SOCIAL SERVICES-OPERATING	11.455
2506	SOCIAL SERVICES-OPERATING	11.460
2507	SOCIAL SERVICES-OPERATING	11.460
2508	SOCIAL SERVICES-OPERATING	11.460
2509	SOCIAL SERVICES-OPERATING	11.460
2510	SOCIAL SERVICES-OPERATING	11.465
2511	SOCIAL SERVICES-OPERATING	11.470
2512	SOCIAL SERVICES-OPERATING	11.470
2513	SOCIAL SERVICES-OPERATING	11.470
2514	SOCIAL SERVICES-OPERATING	11.470
2515	SOCIAL SERVICES-OPERATING	11.470
2516	SOCIAL SERVICES-OPERATING	11.470
2517	SOCIAL SERVICES-OPERATING	11.470
2518	SOCIAL SERVICES-OPERATING	11.475
2519	SOCIAL SERVICES-OPERATING	11.475
2520	SOCIAL SERVICES-OPERATING	11.480
2521	SOCIAL SERVICES-OPERATING	11.480
2522	SOCIAL SERVICES-OPERATING	11.480
2523	SOCIAL SERVICES-OPERATING	11.480
2524	SOCIAL SERVICES-OPERATING	11.480
2525	SOCIAL SERVICES-OPERATING	11.480
2526	SOCIAL SERVICES-OPERATING	11.480
2527	SOCIAL SERVICES-OPERATING	11.480
2528	SOCIAL SERVICES-OPERATING	11.480
2529	SOCIAL SERVICES-OPERATING	11.480
2530	SOCIAL SERVICES-OPERATING	11.485
2531	SOCIAL SERVICES-OPERATING	11.485
2532	SOCIAL SERVICES-OPERATING	11.490
2533	SOCIAL SERVICES-OPERATING	11.500
2534	SOCIAL SERVICES-OPERATING	11.505
2535	SOCIAL SERVICES-OPERATING	11.505
2536	SOCIAL SERVICES-OPERATING	11.505
2537	SOCIAL SERVICES-OPERATING	11.505
2538	SOCIAL SERVICES-OPERATING	11.505
2539	SOCIAL SERVICES-OPERATING	11.505
2540	SOCIAL SERVICES-OPERATING	11.505
2541	SOCIAL SERVICES-OPERATING	11.505
2542	SOCIAL SERVICES-OPERATING	11.505
2543	SOCIAL SERVICES-OPERATING	11.505
2544	SOCIAL SERVICES-OPERATING	11.505
2545	SOCIAL SERVICES-OPERATING	11.505
2546	SOCIAL SERVICES-OPERATING	11.505
2547	SOCIAL SERVICES-OPERATING	11.505
2548	SOCIAL SERVICES-OPERATING	11.505
2549	SOCIAL SERVICES-OPERATING	11.510
2550	SOCIAL SERVICES-OPERATING	11.510
2551	SOCIAL SERVICES-OPERATING	11.510
2552	SOCIAL SERVICES-OPERATING	11.510

Exhibit A

#	Agency	Budget Appropriation Line
2553	SOCIAL SERVICES-OPERATING	11.510
2554	SOCIAL SERVICES-OPERATING	11.510
2555	SOCIAL SERVICES-OPERATING	11.510
2556	SOCIAL SERVICES-OPERATING	11.510
2557	SOCIAL SERVICES-OPERATING	11.510
2558	SOCIAL SERVICES-OPERATING	11.510
2559	SOCIAL SERVICES-OPERATING	11.515
2560	SOCIAL SERVICES-OPERATING	11.520
2561	SOCIAL SERVICES-OPERATING	11.520
2562	SOCIAL SERVICES-OPERATING	11.520
2563	SOCIAL SERVICES-OPERATING	11.520
2564	SOCIAL SERVICES-OPERATING	11.525
2565	SOCIAL SERVICES-OPERATING	11.525
2566	SOCIAL SERVICES-OPERATING	11.530
2567	SOCIAL SERVICES-OPERATING	11.530
2568	SOCIAL SERVICES-OPERATING	11.535
2569	SOCIAL SERVICES-OPERATING	11.540
2570	SOCIAL SERVICES-OPERATING	11.540
2571	SOCIAL SERVICES-OPERATING	11.545
2572	SOCIAL SERVICES-OPERATING	11.545
2573	SOCIAL SERVICES-OPERATING	11.550
2574	SOCIAL SERVICES-OPERATING	11.550
2575	SOCIAL SERVICES-OPERATING	11.550
2576	SOCIAL SERVICES-OPERATING	11.551
2577	SOCIAL SERVICES-OPERATING	11.555
2578	SOCIAL SERVICES-OPERATING	11.555
2579	SOCIAL SERVICES-OPERATING	11.555
2580	SOCIAL SERVICES-OPERATING	11.555
2581	SOCIAL SERVICES-OPERATING	11.565
2582	SOCIAL SERVICES-OPERATING	11.575
2583	SOCIAL SERVICES-OPERATING	11.580
2584	SOCIAL SERVICES-OPERATING	11.585
2585	SOCIAL SERVICES-OPERATING	11.590
2586	SOCIAL SERVICES-OPERATING	11.595
2587	SOCIAL SERVICES-OPERATING	11.600
2588	GOVERNOR-OPERATING	12.005
2589	GOVERNOR-OPERATING	12.005
2590	GOVERNOR-OPERATING	12.005
2591	GOVERNOR-OPERATING	12.005
2592	SECRETARY OF STATE-OPER	12.055
2593	SECRETARY OF STATE-OPER	12.055
2594	SECRETARY OF STATE-OPER	12.055
2595	SECRETARY OF STATE-OPER	12.055
2596	SECRETARY OF STATE-OPER	12.055
2597	SECRETARY OF STATE-OPER	12.055
2598	SECRETARY OF STATE-OPER	12.055
2599	SECRETARY OF STATE-OPER	12.055
2600	SECRETARY OF STATE-OPER	12.055
2601	SECRETARY OF STATE-OPER	12.055
2602	SECRETARY OF STATE-OPER	12.055
2603	SECRETARY OF STATE-OPER	12.060
2604	SECRETARY OF STATE-OPER	12.065
2605	SECRETARY OF STATE-OPER	12.070
2606	SECRETARY OF STATE-OPER	12.075
2607	SECRETARY OF STATE-OPER	12.090
2608	SECRETARY OF STATE-OPER	12.090
2609	SECRETARY OF STATE-OPER	12.090
2610	SECRETARY OF STATE-OPER	12.100

Exhibit A

#	Agency	Budget Appropriation Line
2611	SECRETARY OF STATE-OPER	12.105
2612	SECRETARY OF STATE-OPER	12.110
2613	SECRETARY OF STATE-OPER	12.115
2614	SECRETARY OF STATE-OPER	12.120
2615	SECRETARY OF STATE-OPER	12.120
2616	SECRETARY OF STATE-OPER	12.135
2617	SECRETARY OF STATE-OPER	12.140
2618	SECRETARY OF STATE-OPER	12.145
2619	SECRETARY OF STATE-OPER	12.150
2620	SECRETARY OF STATE-OPER	12.155
2621	STATE AUDITOR-OPERATING	12.165
2622	STATE AUDITOR-OPERATING	12.165
2623	STATE AUDITOR-OPERATING	12.165
2624	STATE AUDITOR-OPERATING	12.165
2625	STATE AUDITOR-OPERATING	12.165
2626	STATE AUDITOR-OPERATING	12.165
2627	STATE AUDITOR-OPERATING	12.165
2628	STATE AUDITOR-OPERATING	12.165
2629	STATE AUDITOR-OPERATING	12.165
2630	STATE TREASURER-OPERATING	12.185
2631	STATE TREASURER-OPERATING	12.185
2632	STATE TREASURER-OPERATING	12.185
2633	STATE TREASURER-OPERATING	12.185
2634	STATE TREASURER-OPERATING	12.185
2635	STATE TREASURER-OPERATING	12.185
2636	STATE TREASURER-OPERATING	12.185
2637	STATE TREASURER-OPERATING	12.185
2638	STATE TREASURER-OPERATING	12.195
2639	STATE TREASURER-OPERATING	12.200
2640	STATE TREASURER-OPERATING	12.205
2641	STATE TREASURER-OPERATING	12.215
2642	STATE TREASURER-OPERATING	12.220
2643	STATE TREASURER-OPERATING	12.225
2644	ATTORNEY GENERAL-OPER	12.245
2645	ATTORNEY GENERAL-OPER	12.245
2646	ATTORNEY GENERAL-OPER	12.245
2647	ATTORNEY GENERAL-OPER	12.245
2648	ATTORNEY GENERAL-OPER	12.245
2649	ATTORNEY GENERAL-OPER	12.245
2650	ATTORNEY GENERAL-OPER	12.245
2651	ATTORNEY GENERAL-OPER	12.245
2652	ATTORNEY GENERAL-OPER	12.245
2653	ATTORNEY GENERAL-OPER	12.245
2654	ATTORNEY GENERAL-OPER	12.245
2655	ATTORNEY GENERAL-OPER	12.245
2656	ATTORNEY GENERAL-OPER	12.245
2657	ATTORNEY GENERAL-OPER	12.245
2658	ATTORNEY GENERAL-OPER	12.245
2659	ATTORNEY GENERAL-OPER	12.245
2660	ATTORNEY GENERAL-OPER	12.245
2661	ATTORNEY GENERAL-OPER	12.245
2662	ATTORNEY GENERAL-OPER	12.245
2663	ATTORNEY GENERAL-OPER	12.245
2664	ATTORNEY GENERAL-OPER	12.245
2665	ATTORNEY GENERAL-OPER	12.245
2666	ATTORNEY GENERAL-OPER	12.245
2667	ATTORNEY GENERAL-OPER	12.245
2668	ATTORNEY GENERAL-OPER	12.245

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#	Agency	Budget Appropriation Line
2669	ATTORNEY GENERAL-OPER	12.245
2670	ATTORNEY GENERAL-OPER	12.245
2671	ATTORNEY GENERAL-OPER	12.245
2672	ATTORNEY GENERAL-OPER	12.245
2673	ATTORNEY GENERAL-OPER	12.245
2674	ATTORNEY GENERAL-OPER	12.245
2675	ATTORNEY GENERAL-OPER	12.245
2676	ATTORNEY GENERAL-OPER	12.245
2677	ATTORNEY GENERAL-OPER	12.245
2678	ATTORNEY GENERAL-OPER	12.245
2679	ATTORNEY GENERAL-OPER	12.250
2680	ATTORNEY GENERAL-OPER	12.255
2681	ATTORNEY GENERAL-OPER	12.255
2682	ATTORNEY GENERAL-OPER	12.260
2683	ATTORNEY GENERAL-OPER	12.260
2684	ATTORNEY GENERAL-OPER	12.260
2685	ATTORNEY GENERAL-OPER	12.260
2686	ATTORNEY GENERAL-OPER	12.260
2687	ATTORNEY GENERAL-OPER	12.260
2688	ATTORNEY GENERAL-OPER	12.260
2689	ATTORNEY GENERAL-OPER	12.265
2690	ATTORNEY GENERAL-OPER	12.270
2691	JUDICIARY-OPERATING	12.300
2692	JUDICIARY-OPERATING	12.300
2693	JUDICIARY-OPERATING	12.300
2694	JUDICIARY-OPERATING	12.305
2695	JUDICIARY-OPERATING	12.305
2696	JUDICIARY-OPERATING	12.310
2697	JUDICIARY-OPERATING	12.310
2698	JUDICIARY-OPERATING	12.310
2699	JUDICIARY-OPERATING	12.310
2700	JUDICIARY-OPERATING	12.310
2701	JUDICIARY-OPERATING	12.315
2702	JUDICIARY-OPERATING	12.315
2703	JUDICIARY-OPERATING	12.325
2704	JUDICIARY-OPERATING	12.325
2705	JUDICIARY-OPERATING	12.325
2706	JUDICIARY-OPERATING	12.335
2707	JUDICIARY-OPERATING	12.335
2708	JUDICIARY-OPERATING	12.340
2709	JUDICIARY-OPERATING	12.340
2710	JUDICIARY-OPERATING	12.340
2711	JUDICIARY-OPERATING	12.340
2712	JUDICIARY-OPERATING	12.340
2713	JUDICIARY-OPERATING	12.340
2714	JUDICIARY-OPERATING	12.340
2715	JUDICIARY-OPERATING	12.340
2716	JUDICIARY-OPERATING	12.340
2717	JUDICIARY-OPERATING	12.345
2718	JUDICIARY-OPERATING	12.350
2719	JUDICIARY-OPERATING	12.355
2720	JUDICIARY-OPERATING	12.355
2721	JUDICIARY-OPERATING	12.360
2722	JUDICIARY-OPERATING	12.370
2723	JUDICIARY-OPERATING	12.370
2724	JUDICIARY-OPERATING	12.370
2725	PUBLIC DEFENDER-OPERATING	12.400
2726	PUBLIC DEFENDER-OPERATING	12.400

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#	Agency	Budget Appropriation Line
2727	PUBLIC DEFENDER-OPERATING	12.400
2728	PUBLIC DEFENDER-OPERATING	12.400
2729	PUBLIC DEFENDER-OPERATING	12.400
2730	PUBLIC DEFENDER-OPERATING	12.400
2731	LEGISLATURE-OPERATING	12.500
2732	LEGISLATURE-OPERATING	12.505
2733	LEGISLATURE-OPERATING	12.515
2734	LEGISLATURE-OPERATING	12.520
2735	LEGISLATURE-LEASING	13.005
2736	JUDICIARY-LEASING	13.005
2737	SECRETARY OF STATE-LEASING	13.005
2738	STATE AUDITOR-LEASING	13.005
2739	ATTORNEY GENERAL-LEASING	13.005
2740	OFFICE ADMINISTRATION-LEAS	13.005
2741	OFFICE ADMINISTRATION-LEAS	13.005
2742	AGRICULTURE-LEASING	13.005
2743	ECONOMIC DEVELOPMENT-LEAS	13.005
2744	ELEM & SEC EDUCATION-LEAS	13.005
2745	HEALTH & SENIOR SERVICES-LEAS	13.005
2746	LABOR & INDUSTRIAL REL-LEAS	13.005
2747	MENTAL HEALTH-LEASING	13.005
2748	MENTAL HEALTH-LEASING	13.005
2749	NATURAL RESOURCES-LEASING	13.005
2750	PUBLIC SAFETY-LEASING	13.005
2751	PUBLIC SAFETY-LEASING	13.005
2752	REVENUE-LEASING	13.005
2753	SOCIAL SERVICES-LEASING	13.005
2754	CORRECTIONS-LEASING	13.005
2755	ELEM & SEC EDUCATION-LEAS	13.005
2756	ELEM & SEC EDUCATION-LEAS	13.005
2757	LABOR & INDUSTRIAL REL-LEAS	13.005
2758	LABOR & INDUSTRIAL REL-LEAS	13.005
2759	AGRICULTURE-LEASING	13.005
2760	ATTORNEY GENERAL-LEASING	13.005
2761	JUDICIARY-LEASING	13.005
2762	NATURAL RESOURCES-LEASING	13.005
2763	HEALTH & SENIOR SERVICES-LEAS	13.005
2764	PUBLIC SAFETY-LEASING	13.005
2765	PUBLIC SAFETY-LEASING	13.005
2766	ECONOMIC DEVELOPMENT-LEAS	13.005
2767	ELEM & SEC EDUCATION-LEAS	13.005
2768	PUBLIC SAFETY-LEASING	13.005
2769	ECONOMIC DEVELOPMENT-LEAS	13.005
2770	NATURAL RESOURCES-LEASING	13.005
2771	SOCIAL SERVICES-LEASING	13.005
2772	ECONOMIC DEVELOPMENT-LEAS	13.005
2773	PUBLIC SAFETY-LEASING	13.005
2774	PUBLIC SAFETY-LEASING	13.005
2775	NATURAL RESOURCES-LEASING	13.005
2776	NATURAL RESOURCES-LEASING	13.005
2777	NATURAL RESOURCES-LEASING	13.005
2778	OFFICE ADMINISTRATION-LEAS	13.005
2779	OFFICE ADMINISTRATION-LEAS	13.005
2780	CORRECTIONS-LEASING	13.005
2781	PUBLIC SAFETY-LEASING	13.005
2782	DIFP-LEASING	13.005
2783	DIFP-LEASING	13.005
2784	NATURAL RESOURCES-LEASING	13.005

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#	Agency	Budget Appropriation Line
2785	ELEM & SEC EDUCATION-LEAS	13.005
2786	DIFP-LEASING	13.005
2787	NATURAL RESOURCES-LEASING	13.005
2788	NATURAL RESOURCES-LEASING	13.005
2789	NATURAL RESOURCES-LEASING	13.005
2790	SECRETARY OF STATE-LEASING	13.005
2791	ECONOMIC DEVELOPMENT-LEAS	13.005
2792	NATURAL RESOURCES-LEASING	13.005
2793	NATURAL RESOURCES-LEASING	13.005
2794	NATURAL RESOURCES-LEASING	13.005
2795	NATURAL RESOURCES-LEASING	13.005
2796	ECONOMIC DEVELOPMENT-LEAS	13.005
2797	SOCIAL SERVICES-LEASING	13.005
2798	NATURAL RESOURCES-LEASING	13.005
2799	ATTORNEY GENERAL-LEASING	13.005
2800	PUBLIC SAFETY-LEASING	13.005
2801	AGRICULTURE-LEASING	13.005
2802	ATTORNEY GENERAL-LEASING	13.005
2803	LABOR & INDUSTRIAL REL-LEAS	13.005
2804	ATTORNEY GENERAL-LEASING	13.005
2805	NATURAL RESOURCES-LEASING	13.005
2806	REVENUE-LEASING	13.005
2807	AGRICULTURE-LEASING	13.005
2808	ATTORNEY GENERAL-LEASING	13.005
2809	NATURAL RESOURCES-LEASING	13.005
2810	NATURAL RESOURCES-LEASING	13.005
2811	ATTORNEY GENERAL-LEASING	13.005
2812	DIFP-LEASING	13.005
2813	PUBLIC SAFETY-LEASING	13.005
2814	JUDICIARY-LEASING	13.005
2815	ELEM & SEC EDUCATION-LEAS	13.005
2816	LABOR & INDUSTRIAL REL-LEAS	13.005
2817	ECONOMIC DEVELOPMENT-LEAS	13.005
2818	AGRICULTURE-LEASING	13.005
2819	LEGISLATURE-LEASING	13.010
2820	JUDICIARY-LEASING	13.010
2821	GOVERNOR-LEASING	13.010
2822	LT. GOVERNOR-LEASING	13.010
2823	SECRETARY OF STATE-LEASING	13.010
2824	STATE AUDITOR-LEASING	13.010
2825	ATTORNEY GENERAL-LEASING	13.010
2826	OFFICE ADMINISTRATION-LEAS	13.010
2827	AGRICULTURE-LEASING	13.010
2828	ECONOMIC DEVELOPMENT-LEAS	13.010
2829	ELEM & SEC EDUCATION-LEAS	13.010
2830	HIGHER EDUCATION-LEASING	13.010
2831	HEALTH & SENIOR SERVICES-LEAS	13.010
2832	LABOR & INDUSTRIAL REL-LEAS	13.010
2833	MENTAL HEALTH-LEASING	13.010
2834	NATURAL RESOURCES-LEASING	13.010
2835	PUBLIC SAFETY-LEASING	13.010
2836	REVENUE-LEASING	13.010
2837	SOCIAL SERVICES-LEASING	13.010
2838	CORRECTIONS-LEASING	13.010
2839	ELEM & SEC EDUCATION-LEAS	13.010
2840	ELEM & SEC EDUCATION-LEAS	13.010
2841	LABOR & INDUSTRIAL REL-LEAS	13.010
2842	LABOR & INDUSTRIAL REL-LEAS	13.010

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#	Agency	Budget Appropriation Line
2843	AGRICULTURE-LEASING	13.010
2844	ATTORNEY GENERAL-LEASING	13.010
2845	NATURAL RESOURCES-LEASING	13.010
2846	HEALTH & SENIOR SERVICES-LEAS	13.010
2847	MENTAL HEALTH-LEASING	13.010
2848	ECONOMIC DEVELOPMENT-LEAS	13.010
2849	STATE TREASURER-LEASING	13.010
2850	LABOR & INDUSTRIAL REL-LEAS	13.010
2851	SOCIAL SERVICES-LEASING	13.010
2852	MENTAL HEALTH-LEASING	13.010
2853	SECRETARY OF STATE-LEASING	13.010
2854	NATURAL RESOURCES-LEASING	13.010
2855	ECONOMIC DEVELOPMENT-LEAS	13.010
2856	MENTAL HEALTH-LEASING	13.010
2857	SOCIAL SERVICES-LEASING	13.010
2858	PUBLIC SAFETY-LEASING	13.010
2859	AGRICULTURE-LEASING	13.010
2860	AGRICULTURE-LEASING	13.010
2861	PUBLIC SAFETY-LEASING	13.010
2862	AGRICULTURE-LEASING	13.010
2863	AGRICULTURE-LEASING	13.010
2864	NATURAL RESOURCES-LEASING	13.010
2865	NATURAL RESOURCES-LEASING	13.010
2866	OFFICE ADMINISTRATION-LEAS	13.010
2867	PUBLIC SAFETY-LEASING	13.010
2868	ECONOMIC DEVELOPMENT-LEAS	13.010
2869	DIFP-LEASING	13.010
2870	DIFP-LEASING	13.010
2871	DIFP-LEASING	13.010
2872	NATURAL RESOURCES-LEASING	13.010
2873	DIFP-LEASING	13.010
2874	ATTORNEY GENERAL-LEASING	13.010
2875	NATURAL RESOURCES-LEASING	13.010
2876	NATURAL RESOURCES-LEASING	13.010
2877	NATURAL RESOURCES-LEASING	13.010
2878	NATURAL RESOURCES-LEASING	13.010
2879	SECRETARY OF STATE-LEASING	13.010
2880	NATURAL RESOURCES-LEASING	13.010
2881	NATURAL RESOURCES-LEASING	13.010
2882	ECONOMIC DEVELOPMENT-LEAS	13.010
2883	SOCIAL SERVICES-LEASING	13.010
2884	NATURAL RESOURCES-LEASING	13.010
2885	SOCIAL SERVICES-LEASING	13.010
2886	PUBLIC SAFETY-LEASING	13.010
2887	AGRICULTURE-LEASING	13.010
2888	AGRICULTURE-LEASING	13.010
2889	ATTORNEY GENERAL-LEASING	13.010
2890	LABOR & INDUSTRIAL REL-LEAS	13.010
2891	ATTORNEY GENERAL-LEASING	13.010
2892	AGRICULTURE-LEASING	13.010
2893	PUBLIC SAFETY-LEASING	13.010
2894	ECONOMIC DEVELOPMENT-LEAS	13.010
2895	ATTORNEY GENERAL-LEASING	13.010
2896	NATURAL RESOURCES-LEASING	13.010
2897	NATURAL RESOURCES-LEASING	13.010
2898	DIFP-LEASING	13.010
2899	OFFICE ADMINISTRATION-LEAS	13.010
2900	AGRICULTURE-LEASING	13.010

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#	Agency	Budget Appropriation Line
2901	ATTORNEY GENERAL-LEASING	13.010
2902	SECRETARY OF STATE-LEASING	13.010
2903	ECONOMIC DEVELOPMENT-LEAS	13.010
2904	AGRICULTURE-LEASING	13.010
2905	NATURAL RESOURCES-LEASING	13.010
2906	LABOR & INDUSTRIAL REL-LEAS	13.010
2907	LABOR & INDUSTRIAL REL-LEAS	13.010
2908	AGRICULTURE-LEASING	13.010
2909	ELEM & SEC EDUCATION-LEAS	13.015
2910	HEALTH & SENIOR SERVICES-LEAS	13.015
2911	MENTAL HEALTH-LEASING	13.015
2912	PUBLIC SAFETY-LEASING	13.015
2913	SOCIAL SERVICES-LEASING	13.015
2914	HEALTH & SENIOR SERVICES-LEAS	13.015
2915	PUBLIC SAFETY-LEASING	13.015
2916	AGRICULTURE-LEASING	13.015
2917	SOCIAL SERVICES-LEASING	13.015
2918	PUBLIC SAFETY-LEASING	13.015
2919	OFFICE ADMINISTRATION-LEAS	13.020
2920	OFFICE ADMINISTRATION-LEAS	13.020
2921	OFFICE ADMINISTRATION-LEAS	13.020
2922	OFFICE ADMINISTRATION-LEAS	13.021
2923	ELEM & SEC EDUCATION-CI	17.005
2924	ELEM & SEC EDUCATION-CI	17.010
2925	HIGHER EDUCATION-CI	17.020
2926	HIGHER EDUCATION-CI	17.030
2927	HIGHER EDUCATION-CI	17.035
2928	HIGHER EDUCATION-CI	17.040
2929	HIGHER EDUCATION-CI	17.045
2930	HIGHER EDUCATION-CI	17.050
2931	HIGHER EDUCATION-CI	17.060
2932	HIGHER EDUCATION-CI	17.075
2933	HIGHER EDUCATION-CI	17.080
2934	HIGHER EDUCATION-CI	17.085
2935	HIGHER EDUCATION-CI	17.090
2936	HIGHER EDUCATION-CI	17.095
2937	HIGHER EDUCATION-CI	17.100
2938	HIGHER EDUCATION-CI	17.105
2939	OFFICE ADMINISTRATION-CI	17.110
2940	OFFICE ADMINISTRATION-CI	17.110
2941	OFFICE ADMINISTRATION-CI	17.110
2942	OFFICE ADMINISTRATION-CI	17.110
2943	OFFICE ADMINISTRATION-CI	17.110
2944	OFFICE ADMINISTRATION-CI	17.110
2945	OFFICE ADMINISTRATION-CI	17.110
2946	OFFICE ADMINISTRATION-CI	17.120
2947	OFFICE ADMINISTRATION-CI	17.120
2948	OFFICE ADMINISTRATION-CI	17.130
2949	OFFICE ADMINISTRATION-CI	17.140
2950	OFFICE ADMINISTRATION-CI	17.150
2951	SOCIAL SERVICES-CI	17.155
2952	PUBLIC SAFETY-CI	17.155
2953	LABOR & INDUSTRIAL REL-CI	17.155
2954	OFFICE ADMINISTRATION-CI	17.160
2955	OFFICE ADMINISTRATION-CI	17.160
2956	PUBLIC SAFETY-CI	17.160
2957	OFFICE ADMINISTRATION-CI	17.170
2958	OFFICE ADMINISTRATION-CI	17.180

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#	Agency	Budget Appropriation Line
2959	OFFICE ADMINISTRATION-CI	17.190
2960	OFFICE ADMINISTRATION-CI	17.200
2961	OFFICE ADMINISTRATION-CI	17.215
2962	OFFICE ADMINISTRATION-CI	17.220
2963	OFFICE ADMINISTRATION-CI	17.225
2964	OFFICE ADMINISTRATION-CI	17.230
2965	OFFICE ADMINISTRATION-CI	17.235
2966	OFFICE ADMINISTRATION-CI	17.235
2967	OFFICE ADMINISTRATION-CI	17.235
2968	AGRICULTURE-CI	17.240
2969	AGRICULTURE-CI	17.245
2970	NATURAL RESOURCES-CI	17.250
2971	NATURAL RESOURCES-CI	17.250
2972	NATURAL RESOURCES-CI	17.250
2973	NATURAL RESOURCES-CI	17.250
2974	NATURAL RESOURCES-CI	17.250
2975	NATURAL RESOURCES-CI	17.250
2976	NATURAL RESOURCES-CI	17.250
2977	NATURAL RESOURCES-CI	17.250
2978	NATURAL RESOURCES-CI	17.255
2979	NATURAL RESOURCES-CI	17.260
2980	NATURAL RESOURCES-CI	17.260
2981	NATURAL RESOURCES-CI	17.260
2982	NATURAL RESOURCES-CI	17.260
2983	NATURAL RESOURCES-CI	17.260
2984	NATURAL RESOURCES-CI	17.260
2985	NATURAL RESOURCES-CI	17.265
2986	NATURAL RESOURCES-CI	17.265
2987	NATURAL RESOURCES-CI	17.265
2988	NATURAL RESOURCES-CI	17.265
2989	NATURAL RESOURCES-CI	17.265
2990	NATURAL RESOURCES-CI	17.265
2991	NATURAL RESOURCES-CI	17.265
2992	NATURAL RESOURCES-CI	17.265
2993	NATURAL RESOURCES-CI	17.265
2994	NATURAL RESOURCES-CI	17.270
2995	NATURAL RESOURCES-CI	17.275
2996	NATURAL RESOURCES-CI	17.280
2997	NATURAL RESOURCES-CI	17.285
2998	NATURAL RESOURCES-CI	17.290
2999	NATURAL RESOURCES-CI	17.295
3000	CONSERVATION-CI	17.300
3001	LABOR & INDUSTRIAL REL-CI	17.310
3002	LABOR & INDUSTRIAL REL-CI	17.310
3003	PUBLIC SAFETY-CI	17.315
3004	PUBLIC SAFETY-CI	17.315
3005	PUBLIC SAFETY-CI	17.315
3006	PUBLIC SAFETY-CI	17.315
3007	PUBLIC SAFETY-CI	17.315
3008	PUBLIC SAFETY-CI	17.315
3009	PUBLIC SAFETY-CI	17.320
3010	PUBLIC SAFETY-CI	17.320
3011	PUBLIC SAFETY-CI	17.325
3012	PUBLIC SAFETY-CI	17.330
3013	PUBLIC SAFETY-CI	17.330
3014	PUBLIC SAFETY-CI	17.335
3015	PUBLIC SAFETY-CI	17.335
3016	PUBLIC SAFETY-CI	17.335

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#	Agency	Budget Appropriation Line
3017	PUBLIC SAFETY-CI	17.335
3018	PUBLIC SAFETY-CI	17.340
3019	PUBLIC SAFETY-CI	17.340
3020	PUBLIC SAFETY-CI	17.345
3021	PUBLIC SAFETY-CI	17.350
3022	PUBLIC SAFETY-CI	17.350
3023	PUBLIC SAFETY-CI	17.355
3024	PUBLIC SAFETY-CI	17.360
3025	PUBLIC SAFETY-CI	17.360
3026	PUBLIC SAFETY-CI	17.370
3027	PUBLIC SAFETY-CI	17.375
3028	PUBLIC SAFETY-CI	17.375
3029	PUBLIC SAFETY-CI	17.380
3030	PUBLIC SAFETY-CI	17.380
3031	CORRECTIONS-CI	17.385
3032	CORRECTIONS-CI	17.390
3033	MENTAL HEALTH-CI	17.395
3034	MENTAL HEALTH-CI	17.400
3035	MENTAL HEALTH-CI	17.405
3036	MENTAL HEALTH-CI	17.415
3037	SOCIAL SERVICES-CI	17.420
3038	SOCIAL SERVICES-CI	17.420
3039	SOCIAL SERVICES-CI	17.435
3040	OFFICE ADMINISTRATION-CI	17.440
3041	ELEM & SEC EDUCATION-CI	18.005
3042	OFFICE ADMINISTRATION-CI	18.010
3043	OFFICE ADMINISTRATION-CI	18.015
3044	OFFICE ADMINISTRATION-CI	18.015
3045	OFFICE ADMINISTRATION-CI	18.015
3046	OFFICE ADMINISTRATION-CI	18.015
3047	OFFICE ADMINISTRATION-CI	18.015
3048	OFFICE ADMINISTRATION-CI	18.015
3049	OFFICE ADMINISTRATION-CI	18.015
3050	OFFICE ADMINISTRATION-CI	18.020
3051	OFFICE ADMINISTRATION-CI	18.020
3052	OFFICE ADMINISTRATION-CI	18.020
3053	OFFICE ADMINISTRATION-CI	18.020
3054	OFFICE ADMINISTRATION-CI	18.020
3055	AGRICULTURE-CI	18.025
3056	NATURAL RESOURCES-CI	18.030
3057	NATURAL RESOURCES-CI	18.035
3058	NATURAL RESOURCES-CI	18.035
3059	NATURAL RESOURCES-CI	18.035
3060	NATURAL RESOURCES-CI	18.035
3061	NATURAL RESOURCES-CI	18.035
3062	NATURAL RESOURCES-CI	18.035
3063	NATURAL RESOURCES-CI	18.035
3064	NATURAL RESOURCES-CI	18.035
3065	NATURAL RESOURCES-CI	18.035
3066	CONSERVATION-CI	18.040
3067	PUBLIC SAFETY-CI	18.045
3068	PUBLIC SAFETY-CI	18.045
3069	PUBLIC SAFETY-CI	18.050
3070	PUBLIC SAFETY-CI	18.050
3071	PUBLIC SAFETY-CI	18.055
3072	CORRECTIONS-CI	18.060
3073	MENTAL HEALTH-CI	18.065
3074	SOCIAL SERVICES-CI	18.070

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#	Agency	Budget Appropriation Line
3075	NATURAL RESOURCES-CI	18.075
3076	MO TRANSPORTATION-CI	19.005
3077	AGRICULTURE-CI	19.010
3078	NATURAL RESOURCES-CI	19.015
3079	NATURAL RESOURCES-CI	19.015
3080	NATURAL RESOURCES-CI	19.015
3081	NATURAL RESOURCES-CI	19.015
3082	CONSERVATION-CI	19.020
3083	PUBLIC SAFETY-CI	19.025
3084	PUBLIC SAFETY-CI	19.025
3085	PUBLIC SAFETY-CI	19.025
3086	PUBLIC SAFETY-CI	19.025
3087	PUBLIC SAFETY-CI	19.030
3088	PUBLIC SAFETY-CI	19.030
3089	PUBLIC SAFETY-CI	19.030
3090	MENTAL HEALTH-CI	19.035
3091	ELEM & SEC EDUCATION-CI	19.040
3092	NATURAL RESOURCES-CI	19.045
3093	NATURAL RESOURCES-CI	19.050
3094	HIGHER EDUCATION-CI	19.055
3095	HIGHER EDUCATION-CI	19.060
3096	HIGHER EDUCATION-CI	19.065
3097	HIGHER EDUCATION-CI	19.070
3098	HIGHER EDUCATION-CI	19.075
3099	HIGHER EDUCATION-CI	19.080
3100	HIGHER EDUCATION-CI	19.085
3101	HIGHER EDUCATION-CI	19.090

**EXECUTIVE ORDER
18-08**

WHEREAS, the United States Department of Justice Bureau of Justice Assistance launched the Justice Reinvestment Initiative in 2006, which provides policymakers with resources and tools to increase public safety, hold offenders accountable, and control corrections costs, resulting in a more effective justice system; and

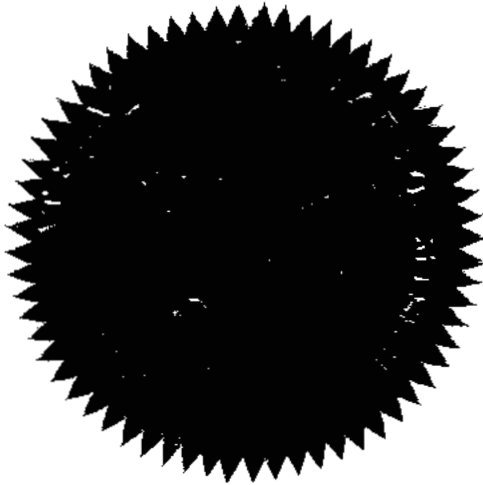
WHEREAS, the Missouri State Justice Reinvestment Task Force, established by Executive Order 17-17 on June 28, 2017, developed comprehensive criminal justice legislation, House Bill No. 1355, which was passed by the General Assembly and signed into law on June 1, 2018; and

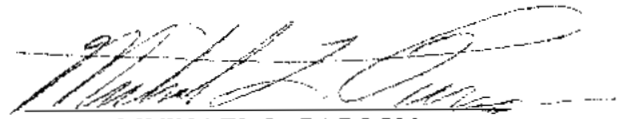
WHEREAS, while the Missouri State Justice Reinvestment Task Force has successfully completed the mission assigned to them, there is still work to be done to improve the efficiency of our state's criminal justice system:

NOW THEREFORE, I, MICHAEL L. PARSON, GOVERNOR OF THE STATE OF MISSOURI, hereby establish the Missouri Justice Reinvestment Executive Oversight Council as follows:


1. The Council shall include the following members or their designees:
 - a. The Lieutenant Governor;
 - b. A member of the Senate from both the majority and minority party appointed by the President Pro Tempore of the Senate;
 - c. A member of the House of Representatives from both the majority and minority party appointed by the Speaker of the House of Representatives;
 - d. A member of the Missouri Supreme Court appointed by the Chief Justice of the Missouri Supreme Court;
 - e. The Director of the Department of Corrections, who shall also serve as chairperson;
 - f. The Director of the Department of Mental Health;
 - g. The Director of the Department of Public Safety;
 - h. The Director of the Department of Social Services;
 - i. The Director of the Department of Economic Development;
 - j. The Chairman of the Parole Board;
 - k. A representative from the Missouri Sheriffs' Association;
 - l. A representative from the Missouri Police Chiefs Association; and
 - m. Such other members as the Governor may appoint.
2. The Council shall advise the Office of the Governor on the implementation of the Missouri Justice Reinvestment Act by soliciting input from advisory groups on implementation protocols, monitoring the progress of multi-agency working groups throughout the state, and providing additional recommendations based on data monitoring in order to foster sustainability of all justice reinvestment efforts.
3. The Council shall submit a report of its actions and recommendations to the Governor no less than annually.
4. The Council shall participate in the United States Department of Justice Bureau of Justice Assistance Justice Reinvestment Initiative (JRI). The JRI may provide assistance to the Council.
5. The Department of Corrections shall provide staff support for the Council.
6. Members of the Council shall not receive any compensation for their duties as members of the Council, but may be reimbursed for necessary expenses associated with performing their duties, subject to the availability of funds.
7. The Council shall dissolve as of December 31, 2020, unless reauthorized or terminated by a subsequent Executive Order.

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, on this 25th day of October, 2018.




MICHAEL L. PARSON
GOVERNOR

ATTEST:


JOHN R. ASHCROFT
SECRETARY OF STATE

Under this heading will appear the text of proposed rules and changes. The notice of proposed rulemaking is required to contain an explanation of any new rule or any change in an existing rule and the reasons therefor. This is set out in the Purpose section with each rule. Also required is a citation to the legal authority to make rules. This appears following the text of the rule, after the word "Authority."

Entirely new rules are printed without any special symbolology under the heading of proposed rule. If an existing rule is to be amended or rescinded, it will have a heading of proposed amendment or proposed rescission. Rules which are proposed to be amended will have new matter printed in boldface type and matter to be deleted placed in brackets.

An important function of the *Missouri Register* is to solicit and encourage public participation in the rulemaking process. The law provides that for every proposed rule, amendment, or rescission there must be a notice that anyone may comment on the proposed action. This comment may take different forms.

If an agency is required by statute to hold a public hearing before making any new rules, then a Notice of Public Hearing will appear following the text of the rule. Hearing dates must be at least thirty (30) days after publication of the notice in the *Missouri Register*. If no hearing is planned or required, the agency must give a Notice to Submit Comments. This allows anyone to file statements in support of or in opposition to the proposed action with the agency within a specified time, no less than thirty (30) days after publication of the notice in the *Missouri Register*.

An agency may hold a public hearing on a rule even though not required by law to hold one. If an agency allows comments to be received following the hearing date, the close of comments date will be used as the beginning day in the ninety- (90-) day-count necessary for the filing of the order of rulemaking.

If an agency decides to hold a public hearing after planning not to, it must withdraw the earlier notice and file a new notice of proposed rulemaking and schedule a hearing for a date not less than thirty (30) days from the date of publication of the new notice.

Proposed Amendment Text Reminder:

Boldface text indicates new matter.

[Bracketed text indicates matter being deleted.]

**Title 6—DEPARTMENT OF HIGHER EDUCATION
Division 10—Commissioner of Higher Education
Chapter 4—Submission of Academic Information, Data
and New Programs**

PROPOSED AMENDMENT

6 CSR 10-4.010 Academic Program Approval. The department is deleting sections (1) and (6), amending sections (2)–(5) and (7)–(10), and renumbering as necessary.

PURPOSE: This amendment sets forth the revised evaluation criteria and procedures for submitting new degree and certificate programs and program changes by public and independent institutions of higher education in Missouri to the Coordinating Board for Higher Education.

[(1) Policy.

(A) In light of its responsibilities imposed and assigned by sections 173.005.2(1) and (7) and 173.030(1) and (2), RSMo, the Coordinating Board for Higher Education (CBHE) has determined that it can and should discharge its obligations by requiring institutions of higher education in the state to submit to it information concerning all new degree and certificate programs. The coordinating board will review all new program proposals and, in the case of public institutions, will approve or disapprove them. In the case of independent institutions, the coordinating board will review the programs and make pertinent recommendations. Although these recommendations are not binding on independent institutions, submission of the proposals is required of independent institutions in order to address the issues of duplication and access at the postsecondary level as well as to enable the coordinating board to fulfill its statutory obligations. Furthermore, compliance with this policy is one (1) of the conditions for the eligibility of independent institutions for participation in the Missouri student grant program.

(B) Sections of this rule that do not apply to independent institutions are those dealing with cooperative intercampus degree programs, staff advisory comments, use of consultants, performance reviews for new programs, joint review with CBHE and the Department of Elementary and Secondary Education and program finances.]

[(2)](1) Definitions.

(A) [Certificate—a prescribed course of study which confers an award other than a formal degree.] CBHE-approved mission—a description of the public institution's programs, audiences served, level and type of degrees offered, or other distinguishing factors which the CBHE has reviewed and approved.

(B) [CIP Taxonomy—the six-digit code number assigned to academic program types by the Center for Educational Statistics of the United States Department of Education. CIP categories are described in the United States Department of Education publication, A Classification of Instructional Programs (CIP).] CBHE-approved off-site location—locations other than the main campus (for universities) or taxing district (for community colleges) that the CBHE has reviewed and approved. The department maintains an official inventory of approved off-site locations.

(C) CBHE-approved service region—a geographic region for which a public institution has responsibility for meeting the educational needs of its residents.

(D) Certificate program—a prescribed course of study which confers an award other than a formal academic degree.

(E) Classification of Instructional Programs (CIP)—a taxonomic scheme that supports the accurate tracking and reporting of fields of study and program completions activity. The CIP is the accepted federal government statistical standard on instructional program classifications developed by the U.S. Department of Education.

(F) Combination programs—the result of a mechanical combination of two (2) previously existing programs.

[(C)](G) Commissioner—the commissioner of higher education as appointed by the CBHE.

[(D)](H) Content—the program specialization with its related options, if any, for which recognition is intended to be given by the conferring of a degree or certificate.

[(E)](I) Coordinating board, board, or CBHE—the Coordinating Board for Higher Education created by [the Omnibus State Reorganization Act, Law 1974, p. 530] article IV, section 52 of the Missouri Constitution.

[(F)](J) Degree—[any prescribed course of study in an institution of higher education which constitutes an area of

specialization leading to a recognized degree. This is the same as the term discipline specialty as represented by the Classification of Instructional Program (CIP) code used in reporting] an award conferred by a college, university, or other postsecondary education institution as official recognition for the successful completion of a program of studies as defined by and reported to the United States Department of Education/[*s Integrated Postsecondary Education Data System*] and to the [Missouri] coordinating board's [for higher education's] certificate and program inventory. In baccalaureate degrees or higher, the term program is generally the same as major.

(K) Department—the Missouri Department of Higher Education created by article IV, section 52 of the Missouri Constitution.

(L) Duplication—proposing to offer the same or a similar program to one that is already being offered by another institution.

(M) Inactive status—the result of formal action by an institution on the status of an existing academic program, which suspends the program for a period not to exceed five (5) years.

[(G)](N) Independent institution—an approved private institution of higher education meeting the requirements of section 173.[205/1102(2), RSMo, provided it is also either accredited or a candidate for accreditation by the [Commission on Institutions of Higher Education of the North Central Association of Colleges and Secondary Schools and provided it offers a postsecondary course of instruction at least two (2) years in length leading to conferral of a degree] Higher Learning Commission.

[(H)](O) Level—a degree, such as associate, baccalaureate, first professional, master's, specialist, doctorate, and any other designation lower, higher, or intermediate to those which now exist or may be created. (Specialist programs, related to the state requirements for the certification of public school administrators and to the further education of public school teachers and supervisors, should be limited specifically to the field of education. These programs are essentially extensions of master's level studies and should evidence a study beyond that expected of master's programs.)

(P) Minor change—modifications to existing programs that do not involve changes to course content, prerequisites, or credit hours, including change of program title or CIP code; combination programs; inactive status; one- (1-) year certificate programs; options; program deletion; single-semester certificate programs.

(Q) Professional Degree—is an award for completing a program that 1) serves as a prerequisite to practicing in the profession; 2) requires at least two (2) years of college work prior to entering the program; and 3) requires a total of at least six (6) academic years of college work to complete the degree program, including prior required college work plus the length of the professional program itself.

[(I)](R) Program—a prescribed course of study that leads to the formal award of a certificate or degree.

1. Certificate 0 (Undergraduate)—Postsecondary award, certificate, or diploma (less than one (1) academic year) below the baccalaureate degree—

A. Less than nine hundred (900) contact or clock hours; or

B. Less than thirty (30) semester or trimester credit hours; or

C. Less than forty-five (45) quarter credit hours.

2. Certificate 1 (Undergraduate)—Postsecondary award, certificate, or diploma (at least one (1), but less than two (2) academic years) below the baccalaureate degree—

A. At least nine hundred (900), but less than one thousand eight hundred (1,800) contact or clock hours; or

B. At least thirty (30), but less than sixty (60) semester or trimester hours; or

C. At least forty-five (45), but less than ninety (90) quar-

ter hours.

3. Associate's degree—an award that normally requires no more than sixty (60) semester credit hours unless necessary for accreditation or licensure.

4. Certificate 2 (Undergraduate)—postsecondary award, certificate, or diploma (at least two (2), but less than four (4) academic years) below the baccalaureate degree—

A. At least one thousand eight hundred (1,800), but less than three thousand six hundred (3,600) contact or clock hours; or

B. At least sixty (60), but less than one hundred twenty (120) semester or trimester credit hours; or

C. At least ninety (90), but less than one hundred eighty (180) quarter credit hours.

5. Baccalaureate degree—an award that normally requires no more than one hundred twenty (120) semester credit hours unless necessary for accreditation or licensure.

6. Graduate certificate—an organized program of study beyond the bachelor's degree, designed for persons who have completed a baccalaureate degree but not meeting requirements of academic degrees at the master's level.

7. Master's degree—an award that typically requires successful completion of a program of study of at least the full-time equivalent of one (1), but not more than two (2) academic years of work beyond the bachelor's degree. Some of these degrees may require more than two (2) full-time equivalent academic years of work.

8. Post-master's certificate (First-professional certificate)—an organized program beyond the master's degree but not meeting requirements of academic degrees at the doctor's level. This award is designed for persons having completed the first-professional degree (refresher courses or additional units of study in a specialty or subspecialty).

9. Doctoral degree—the highest award a student can earn for graduate study (research/scholarship or professional practice).

(S) Program deletion—the removal of a program or an option from an institution's program offerings.

(T) Program change—any revision or change in a program name or its nomenclature, including CIP number.

[(J)](U) Public institution—an approved public institution of higher education meeting the requirements of section 173.[205/1102(3), RSMo], provided it is also either accredited or a candidate for accreditation by the Commission on Institutions of Higher Education of the North Central Association of Colleges and Secondary Schools, and provided it offers a postsecondary course of instruction at least two (2) years in length leading to conferral of a degree].

[(K)](V) Program option/s/ or option—a formally designated area of specialization within an existing degree program that has a distinctive curricular pattern. A [preponderance] majority of required courses for the option will be taken in a core of courses common to all variations of the existing parent degree. For the purposes of program changes, option, emphasis area, and other similar terms are assumed to be equivalent.

(W) Substantive curricular change—significant modifications or expansion of an existing program. Examples of substantive changes include, but are not limited to, a change in the program's overall credits or goals; deletion and replacement of a significant number of courses in the program's curriculum; change in the primary mode of delivery; change in the program's purpose; change in the audience(s) that the program is intended to serve.

[(L)](X) Program [T/type or type of program—A designation within a degree level, such as associate of arts(AA), associate of science (AS), associate of applied science (AAS), bachelor of arts, bachelor of science, bachelor of science in engineering, master of arts, master of science, doctor of philosophy, doctor of education, etc. [AA and AS degrees are oriented toward transfer to baccalaureate

programs. AAS degrees are not oriented toward transfer to baccalaureate programs, but rather are terminal vocational programs.]

[(3)](2) [General Program Approval] Special Procedure[s] for New Public Institutions.

[(A) The coordinating board or its designee shall be responsible for the review of all new program proposals and shall either approve or disapprove them. Institutions submitting new programs for CBHE review shall follow the format outlined by CBHE staff. Submissions shall be made on appropriate forms as provided by the CBHE. All actions resulting in the approval of new programs for public institutions shall be subject to a stipulation regarding the program's ability to attain specified performance goals during a stipulated period that shall have been established by the sponsoring institution and shall have been approved by the board or its designee.

(B) Performance Review. At the conclusion of the stipulated period, the program's performance shall be reviewed on the basis of the specified goals in a manner mutually satisfactory to the sponsoring institution and the commissioner. In the event a new program fails to develop satisfactorily in the allotted period as determined by the board or its designee, the status of the new program shall be evaluated. As a result of this review, approval may be continued with or without further stipulations, or program authorization may be withdrawn. In the latter event, should the sponsoring institution choose to continue the new program rather than terminate it, the resources associated with the program shall be withdrawn from the institution's funding base for the purpose of developing future state appropriation requests.

(C) Special Procedure for New Public Institutions.]

[1.](A) Since newly-established public institutions have ordinarily only begun the process of assembling the resources necessary to offer instruction, application of the usual [and customary] review process would [not] be inappropriate. As a consequence, new public institutions must develop a five- (5-)[-] year academic plan that projects those programs the institution intends to develop during this period based upon a need analysis it has conducted. The institution must also provide satisfactory evidence that it can reasonably expect to acquire the resources necessary to support these programs. The institution must submit annual updates on the plan and its progress toward full implementation. At these times the institution may request revisions in its original plan.

[2.](B) Subject to [coordinating board] CBHE approval of the plan, the new institution may offer these programs for a period not to exceed five (5) years. During this time the institution must submit formal proposals for new program approval; however, the submission of these programs may occur on a schedule convenient to the institution. Those programs that have not received regular approval by the end of the five- (5-)[-] year planning period shall be terminated, or the resources associated with the program shall be withdrawn from the institution's funding base for the purpose of developing future state appropriation requests.

[(D)](C) Notice. Prompt notice of the results of all academic program approval and review actions by the board or its designee, including any pertinent comments relating thereto, [shall] will be sent to the [Coordinating Board for Higher Education] CBHE whenever the action decision has been delegated, to all higher education institutions and to the public in a manner deemed appropriate by the commissioner.

[(4)](3) General Program Review [Policies] for Independent Institutions. Except for subsections (4)(A), (4)(B), the right to appeal provided in section (8), and any pertinent definitions in section (1), this rule does not apply to independent institutions. Independent institutions shall submit all new degree and certi-

cate programs for CBHE review according to the procedure in either subsection (4)(A) or (4)(B), as determined by department staff. The CBHE may offer nonbinding recommendations on such program proposals, and may use submitted information to aid the analysis of public institutions' program proposals. Submission of new program information is a prerequisite to receiving any funds administered by the CBHE in accordance with section 173.005.2(9) and (10), RSMo, but receipt of such funds does not depend on receipt or compliance with CBHE comments or recommendations. In no event, section (4) of this rule notwithstanding, will independent institutions' program proposals be subject to CBHE approval.

[(A) Independent institutions shall submit all new degree and certificate programs for coordinating board review. Institutions submitting new programs for CBHE review shall follow the general format used by public institutions. Submissions should be made on appropriate forms as provided by the CBHE.

(B) The board or its designee shall review new program proposals submitted by independent institutions and may make pertinent comments and recommendations. Although these recommendations are not binding on independent institutions, submission of the proposals is required of independent institutions to address the issues of duplication and access at the postsecondary level as well as to enable the CBHE to fulfill its statutory obligations. Compliance with this policy is one (1) of the conditions for the eligibility of independent institutions for participation in the Missouri student grant program.

(C) The board or its designee shall ensure that the review of new programs submitted by independent institutions is conducted in a manner to provide that all criteria and definitions that are applicable to public institutions are also applicable to independent institutions except as explicitly provided in this rule. These criteria, however, shall be applied with due regard for the differences between public and independent institutions as well as the different degree of responsibility and authority the coordinating board and state have in the operation of the respective sectors.

(D) With respect to permissible differences in the review process between independent and public institutions, the following criteria, procedures and definitions shall not be applicable to independent institutions unless an individual independent institution should voluntarily elect to participate in a particular review provision:

1. All financial criteria shall not be applicable and related data should not be submitted;

2. Provisions related to cooperative intercampus degree programs shall not be applicable;

3. Provisions related to staff advisory comments shall not be applicable;

4. Provisions related to performance reviews for new programs shall not be applicable;

5. Provisions related to the use of consultants shall not be applicable; and

6. Provisions related to the joint review of vocational programs by the coordinating board and the Department of Elementary and Secondary Education shall not be applicable.

(E) Notice. Prompt notice of the results of all academic program review actions by the CBHE or its designee, including any pertinent comments relating thereto, shall be sent to the Coordinating Board for Higher Education whenever the action decision has been delegated, to all higher education institutions and to the public in a manner deemed appropriate by the commissioner.]

(4) Types of Review.

(A) Staff Review.

1. Minor changes to existing academic programs and the addition of some certificates may be addressed through a staff review. Institutions shall report all minor changes to ensure that the state program inventory is accurate and complete.

2. Requests for minor changes to existing academic programs must be submitted to the department on forms provided by the department. The following guidelines apply to specific change requests:

A. Moving an existing program to inactive status.

(I) Programs placed on inactive status will be suspended for a specified period not to exceed five (5) years.

(II) Students in the program at the time this status is adopted will be permitted to conclude their course of study if they have no more than two (2) years of coursework remaining, but no new students may be admitted to the program.

(III) At the conclusion of the designated inactive period, not to exceed five (5) years, the institution must review the program's status and may either delete it or reactivate it.

(IV) Only programs and certificates may be placed in inactive status; options are deleted through the program deletion process;

B. Program deletion. At the time an institution notifies the Higher Learning Commission (HLC) in writing about the circumstances for which HLC requires a teach-out agreement, the institution must also notify the department. Institutions must provide program name, level, CIP code, and effective date of deletion;

C. Location notification. This includes change of address updates, and notifications of closed locations. Notifications of closed locations must also include the list of programs to be deleted at the location;

D. Change of program title or CIP code. A title, CIP code, or nomenclature revision that includes substantive curriculum changes may be deemed tantamount to a new program and may be referred to the institution for consideration at the routine or comprehensive review level;

E. Combination programs. Combination programs will be reviewed at the staff review level for the elimination of duplicated requirements. The development of interdisciplinary programs and area study programs that utilize the resources of several existing programs will be reviewed through the routine or comprehensive new program approval process. However, proposals that combine two (2) or more programs ordinarily involve a substantive curricular change, which must be reviewed in the comprehensive process described in subsection (5)(C);

F. Certificate programs. Single-semester certificate programs, either as a stand-alone or as part of a parent-degree program, will be considered under staff review. A one- (1-) year certificate may be considered under staff review only if developed from, directly related to, and deriving courses predominantly from an approved parent degree program. Otherwise, one- (1-) year certificate proposals must be submitted as a new program at the routine or comprehensive review level, as appropriate;

G. Graduate certificates. Graduate certificates greater than a single semester in length may be approved at the staff review level if they are part of an existing approved parent degree program. Graduate certificates greater than a single semester that are not part of an approved parent degree must be submitted as a new program at the routine or comprehensive review level, whichever is appropriate; and

H. Adding an option to an existing program. The addition of a specialized course of study as a component of an umbrella degree program may be submitted as a program change subject to a determination by the CBHE or its designee regarding the potential for unnecessary or inappropriate duplication of existing programs, in accordance with subsection (9)(C) of this rule. Only in those instances in which duplication is necessary and appropriate may the proposed option be implemented. Options within

a parent degree program will have the same CIP code as the parent degree. The institution shall provide evidence that the proposed option functions as a component of an umbrella degree program, including the curriculum common to the parent degree and all of its options.

(I) The following general guidelines distinguish a permissible option addition from a proposed new degree program:

(a) An option or emphasis area generally functions as a component of an umbrella degree program. As such, an option in a specialized topic will consist of a core area of study in the major plus selected topical courses in the specialty. Typically, the core area of study will constitute a majority of the requirements in the major area of study as measured in the number of required courses or credit hours;

(b) A proposed option or emphasis area must be a logical component or extension of the umbrella degree program. One (1) measure of this compatibility—but not the only one—would be the consonance of the proposed addition with the federal CIP taxonomy. For instance, using physics as an example, optics would be an appropriate option (emphasis area) while astrophysics would ordinarily not be acceptable as it is typically viewed as a branch of astronomy rather than physics;

(c) The number of new courses required to implement a new option or emphasis area is relevant. Four (4) or more new courses in a proposed new option will raise questions about resource commitments and suggest that a new program has been developed; and

(d) The need to develop new courses as a condition of implementing an option is a relevant consideration.

3. Review and reporting. Department staff will review requests for minor changes to existing academic programs. Department staff may request additional information from the proposing institution.

4. Timeline. For all requests submitted by the first of the month, department staff will process, review, and report back to institutions by the end of that same month. Department staff will report routine review actions to the CBHE at the next regular board meeting following completion of review.

(B) Routine Review.

1. Proposals for new academic programs that are not minor, but do not constitute a significant change in an institution's current role, scope, or mission will be reviewed under the routine review process. For a proposed program to be considered through routine review, it must meet all of the following criteria:

A. The program is clearly within the institution's CBHE-approved mission;

B. The program will be offered within the proposing institution's CBHE-approved service region;

C. The program will not unnecessarily duplicate an existing program in the applicable geographic area, as described in subsection (9)(C) of this rule;

D. The program will be offered at the main campus or at a CBHE-approved off-site location;

E. The program will build on existing programs and faculty expertise; and

F. The cost to launch the program will be minimal and within the institution's current operating budget.

2. The following proposals generally will be considered under the routine review process:

A. Substantive curricular changes to an existing program;

B. Delivery of an approved program at a CBHE-approved off-site location; and

C. New degree programs offered in collaboration with an institution already approved to offer such a program.

3. Process.

A. Institutions shall provide information about the proposed program to the department on forms provided by the department. This information will include certification that the

proposal meets the criteria for routine review and that the program meets the criteria for all new academic programs. Department staff may request additional information from the proposing institution.

B. Department staff will verify and post the proposal on the department's website to allow for twenty (20) days of public review and comment. Any institution, member of the profession, occupation, or specialized academic field, and any other interested individual may express an opinion to department staff regarding any new program proposal. Comments must be received within twenty (20) days of the proposal's posting on the department website.

C. The proposing public institution will address comments and feedback received. Once all concerns are resolved, the commissioner will recommend provisional approval of the program for a period of five (5) years.

(I) The public institution shall establish clearly defined performance goals for the new program to be achieved during the provisional implementation period. The public institution may revise its performance goals for the new program at any time during the designated implementation period with the concurrence of department staff.

(II) Provisional approval by the CBHE or its designee is valid for two (2) years following the first fall term after CBHE approval. If an institution has not implemented the proposal by that date, the approval will lapse and the program proposal must be resubmitted with updated information.

D. At the end of the five- (5-) year provisional approval period, the department will review the program's viability to determine whether the CBHE's provisional approval should become unconditional, remain provisional pending further review in two (2) years, or be terminated.

(I) Public institutions shall provide to department staff, in a manner prescribed by department staff, enrollment, graduation, and staffing data for the program, as well as a brief summary of program performance. If the program is performing as well as or better than the projections in the original program proposal, the department will recommend that the CBHE approve the program unconditionally.

(II) If the CBHE terminates provisional approval, the public institution shall take the necessary steps to close the program, which includes accommodating students currently enrolled in the program.

4. Timeline.

A. Requests submitted by the first of the month will be reviewed and processed, and in most cases institutions will be notified, by the end of that same month. Department staff will report routine review actions to the CBHE at the next regular board meeting following completion of review.

(C) Comprehensive Review.

1. Proposed new academic programs that meet any of the following criteria will be subject to a comprehensive review:

A. The program will be offered outside the institution's CBHE-approved service region;

B. The institution will incur substantial costs to launch and sustain the program;

C. The program will include the offering of degrees at the baccalaureate level or higher that fall within the Classification of Instructional Programs (CIP) code of 14, Engineering;

D. The program is outside an institution's CBHE-approved mission;

E. The program will include the offering of a doctoral degree, as further described in paragraph (9)(C)3. of this rule (applicable only to non-University of Missouri institutions);

F. The program will include the offering of a professional degree, as further described in paragraph (9)(C)3. of this rule (applicable only to non-University of Missouri institutions); or

G. The program will include the offering of an education

specialist degree.

2. Elements of a Complete Proposal for Comprehensive Review. Institutions shall submit the proposal to the department on forms provided by the department. A complete proposal includes the following:

A. Evidence of good faith effort to explore the feasibility of collaboration with other institutions whose mission or service region encompasses the proposed program. At a minimum, this will include letters from the chief academic officers of both the proposing institution and other institutions involved in exploring the feasibility of collaborative attesting to the nature of the discussions and explaining why collaboration in this instance is not feasible;

B. Evidence that the offering institution is contributing substantially to the CBHE's *Blueprint for Higher Education* as adopted on February 4, 2016, pursuant to section 173.020(4), RSMo, and is committed to advancing the goals of that plan;

C. Evidence of institutional capacity to launch the program in a high-quality manner, including:

(I) An external review conducted by a team including faculty experts in the discipline to be offered and administrators from institutions already offering programs in the discipline and at the degree level proposed. The review must include an assessment of the offering institution's capacity to offer the new program in terms of general, academic, and student service support, including faculty resources that are appropriate for the program being proposed (e.g. faculty credentials, use of adjunct faculty, and faculty teaching workloads);

(II) A comprehensive cost/revenue analysis summarizing the actual costs for the program and information about how the institution intends to fund and sustain the program;

(III) Evidence indicating there is sufficient student interest and capacity to support the program, and, where applicable, sufficient capacity for students to participate in clinical or other external learning requirements, including library resources, physical facilities, and instruction equipment; and

(IV) Where applicable, a description of accreditation requirements for the new program and the institution's plans for seeking accreditation; and

D. Evidence that the proposed program is needed, including:

(I) Documentation demonstrating that the program does not unnecessarily duplicate other programs in the applicable geographic area, as described in subsection (9)(C) of this rule;

(II) A rigorous analysis demonstrating a strong and compelling workforce need for the program, which might include data from a credible source, an analysis of changing program requirements, the current and future workforce, and other needs of the state, and letters of support from local or regional businesses indicating a genuine need for the program; and

(III) A clear plan to meet the articulated workforce need, including:

(a) Aligning curriculum with specific knowledge and competencies needed to work in the field(s) or occupation(s) described in the workforce need analysis in part (II) of this subparagraph;

(b) Providing students with external learning experiences to increase the probability that they will remain in the applicable geographic area after graduation; and

(c) A plan for assessing the extent to which the new program meets that need when implemented.

3. Process.

A. Department staff will verify and post the proposal on the department's website to allow for twenty (20) days of public review and comment. Any institution, member of the profession, occupation, or specialized academic field, and any other interested individual may express an opinion to department staff regarding

any new program proposal. Comments must be received within twenty (20) days of the proposal's posting on the department's website.

B. Department staff, in consultation with the external review team described in part (4)(C)2.C.(I) of this rule, will review a complete proposal and provide feedback to the proposing institution.

C. The proposing public institution will address comments and feedback received. Once all concerns are resolved, the commissioner will recommend provisional approval of the program for a period of five (5) years.

(I) Public institutions shall establish clearly defined performance goals for the new program to be achieved during the provisional implementation period. The public institution may revise its performance goals for the new program at any time during the designated implementation period with the concurrence of department staff.

(II) Public institutions must report annually to the CBHE on the number of students completing the program, financial performance of the program, job placement rates of program graduates, success on any applicable licensure exams, and the extent to which the program is meeting the needs it was designed to address.

(III) Provisional approval by the CBHE or its designee is valid for two (2) years following the first fall term after CBHE approval. If an institution has not implemented the proposal by that date, the approval will lapse and the program proposal must be resubmitted with updated information.

D. At the end of the five- (5-) year provisional approval period, the department will review the program's viability to determine whether the CBHE's provisional approval should become unconditional, remain provisional pending further review in two (2) years, or be terminated.

(I) Public institutions shall provide to department staff, in a manner prescribed by department staff, enrollment, graduation, and staffing data for the program, as well as a brief summary of program performance. If the program is performing as well as or better than the projections in the original program proposal, the department will recommend that the CBHE approve the program unconditionally.

(II) If the CBHE terminates provisional approval, the public institution shall take the necessary steps to close the program, which includes accommodating students currently enrolled in the program.

4. Timeline.

A. Proposals must be submitted to the CBHE by July 1 of each year. The CBHE, in its sole discretion, will determine which proposals to evaluate, and will announce its evaluation decision(s) in September. Final decisions to approve programs will ordinarily be made by February.

B. Comprehensive reviews will be phased in to the program approval process.

(I) In the 2017-2018 review cycle, the CBHE will consider no more than three (3) proposals, in total, to offer a degree outside an institution's CBHE-approved mission. No more than two (2) proposals may come from either public universities or public two- (2-) year institutions during this review cycle.

(II) In the 2018-2019 review cycle, the CBHE will consider no more than five (5) proposals, in total, to offer a degree outside an institution's CBHE-approved mission. No more than three (3) proposals may come from either public universities or public two- (2-) year institutions during this review cycle.

(III) If changes to statutes or licensure requirements warrant the authorization of more than one (1) institution to propose a program requiring a comprehensive review, such proposals may be considered as a single proposal for purposes of this section only.

(IV) Each individual institution's proposal will be eval-

uated on its own merits.

(V) After two (2) proposal cycles, the CBHE may reconvene a task force to evaluate the new framework and to recommend improvements for the CBHE's consideration.

(5) [Submission of Proposals] Off-campus and Out-of-district Degrees and Courses.

[(A) Program Review Schedule.

1. Except as otherwise noted in this rule, proposals for degree and certificate programs must be submitted at least one hundred twenty (120) days prior to implementation and should be submitted to the Missouri Coordinating Board for Higher Education during one (1) of the following three (3) periods each year:

A. March 1 through March 31;

B. July 1 through July 31; and

C. November 1 through November 30.

2. Every effort will be made to complete the review of proposals received in each of these periods during the following one hundred twenty (120)-day cycles (which will begin on April 1, August 1 and December 1), unless unusual circumstances require more time for review of a particular program. The CBHE or its designee may permit departure from this schedule, if necessary, but the sponsoring institution shall be notified of the delay and the reasons for it. The sponsoring institution may request an expedited review of a proposed program in extenuating circumstances by informing the commissioner in writing of the reasons for the request. Pending degree programs shall not be implemented until coordinating board action has been completed.

[(B) Off-campus and Out-of-district Degrees and Courses.]

[1.](A) In addition to submitting proposals for new certificate and degree programs for on-campus offerings, an institution must submit a new program proposal if more than half the major requirements for the degree can be completed at an off-campus site for four- (4-)/- year institutions or at an out-of-district site for two- (2-)/- year institutions. (For the purposes of this section, major requirements [shall be considered to] include course requirements in the specific area of concentration only; general education requirements and free electives [shall] will not be a factor in this determination.)

[2.](B) All formal two-plus-two (2 + 2) curricular agreements must be submitted for review if either the sponsoring institution or the host institution is publicly supported.

(C) [Instructional Site Defined. In the context of the previous subsection, instructional site shall be defined to include only those settings where instruction is delivered directly to students by a physically present teacher. Internship sites and the simple receipt of telecommunications transmissions shall ordinarily not constitute an instructional site. However, programs identified for delivery by such nontraditional means as telecommunications must be submitted for review, and the subsequent review shall focus on instructional delivery at the point of origin. All customary review criteria shall be applicable to programs delivered by nontraditional means.] Types of Off-Campus Instructional Sites Requiring CBHE Approval. The following off-campus instruction sites require CBHE approval:

1. Residence centers, as defined in 6 CSR 10-6.020(1);

2. Off-campus instruction as defined in 6 CSR 10-6.030(1)(C); and

3. Out-of-district instruction as defined in 6 CSR 10-6.030(1)(D).

(D) Special Procedure for Multiple-campus Institutions.

1. Multiple-campus four- (4-)/- year institutions must submit separate program proposals for individual campuses, subject to certain exceptions for cooperative degree programs that are defined in subsequent paragraphs. For the purposes of cooperative degree programs, residence centers [shall] are not [be regarded as] separate

campuses.

2. New program authorization for one (1) campus of a multiple-campus two- (2-)/- year public institution may be extended to all other campuses within a district at the discretion of the sponsoring institution *[subject to the stipulation that]*, **provided the [coordinating board shall be informed] sponsoring institution informs the CBHE** of all academic programming available at each campus.

(E) Cooperative Intercampus Degree Program for Public Institutions.

1. A cooperative[,/] intercampus degree program extends an academic program authorized by the CBHE on one (1) of an institution's campuses to one (1) or more of its other campuses (not including residence centers) under the following conditions:

A. The campus authorized to provide the program will continue to do so;

B. The program is cooperative in nature, that is, it involves the faculty and resources of each participating campus;

C. The program *[shall]* **must** be included in the institution's plan and *[shall]* be consistent with the mission statement for the receiving campus; and

D. The program *[shall]* **must** meet the accreditation guidelines of the appropriate national accrediting body, if any exists, as well as any applicable state licensure requirements.

2. Subject to the previously mentioned definition, a cooperative[,/] intercampus program is distinct from the more typical new program model in which a program is developed as a new, free-standing entity on a campus.

3. The procedures and criteria for the review of *[these] cooperative intercampus programs [shall be]* are the following:

A. Following the endorsement by the president and the governing board of the institution, the program shall be sent to the *[board]* CBHE or its designee for review **at least one hundred twenty (120) days prior to the proposed implementation;**

[B. Each cooperative, intercampus program shall be shared with the CBHE staff for its review and consideration at least one hundred twenty (120) days prior to the proposed implementation;]

[C./B. It [shall be] is the institution's responsibility to document the economic development opportunity or the need the proposed program is designed to address, including specific [manpower] workforce needs at the state or regional level;

[D./C. Additional expenditures associated with the proposed program [shall] will be defined. If the resource needs cannot be satisfactorily addressed by internal reallocation or alternative delivery systems, the program [shall] will be included in the institution's next budget request for state support; and

[E./D. The [board] CBHE or its designee [shall] will review the cooperative[,/] intercampus program on an expedited basis involving a period not to exceed sixty (60) days. In the event the program is not approved by the board's designee, the decision may be appealed to the [coordinating board] CBHE following established program appeal procedures.

[4. This subsection is not applicable to independent institutions.

(F) Staff Advisory Comment for Public Institutions.

1. *The first step in the approval process for free-standing new degree programs is known as the staff advisory comment (SAC) and applies to public institutions only. The SAC report enables the coordinating board staff to make preliminary judgments regarding a program proposed by a public institution prior to the preparation of an entire program proposal document and initiation of the internal approval process at the institutional level. The process also enables the sponsoring institution to anticipate and address issues that might be relevant during the full review. A favorable staff advisory comment does not guarantee final approval of the program when staff reviews the full proposal. Conversely, an unfavor-*

able staff advisory comment does not necessarily mean that the final proposal for a program will not be approved. It will be expected, however, that staff concerns expressed in the staff advisory comment will be addressed in the final proposal.

2. *The SAC report will emphasize those program approval criteria listed in this rule which are relatively stable in the short- to mid-term and which cannot be readily adjusted to different circumstances or perceived needs.*

A. *Mission and planning priorities of sponsoring institution. Each proposal shall include a statement regarding the compatibility of the proposed program with an institution's mission and approved institutional plan or plan update.*

B. *Need for the proposed program. Each proposal shall address the issues of what are the societal, occupational, research and public service needs the program is intended to address as well as the anticipated student demand for the program, preliminary evidence related to market demand for program graduates and the relationship of the program to the economic development of the state, as may be appropriate.*

C. *Duplication of the proposed program. Each proposal shall comment on the issue of the extent to which any existing programs in the proposed service area already address the needs and purposes this program is designed to fulfill. Factors salient to the duplication issue include the relevance of existing programming, the availability of alternative educational delivery systems, extent of student demand, state or regional manpower requirements and access considerations.*

3. *To provide a frame of reference so the responses to these questions can be properly understood, it will also be necessary to submit a brief description of each program including an outline of the proposed curriculum. The structure of the proposed curriculum will not be subject to comment in this phase of the review process, and the CBHE staff will assume that the details of these descriptive materials may be subject to modification as the program development process proceeds. However, if additional planning suggests that a major shift in program emphasis would be appropriate, a new document must be submitted for a staff advisory comment.*

4. *All documents related to this process should be submitted in duplicate. Materials related to a staff advisory comment may be submitted at any time during the year. Every effort will be made to complete a staff advisory comment within forty-five (45) days of submission.*

(G) Proposal for a New Academic Degree Program.

1. *A proposal for a new academic degree program shall be submitted during one (1) of three (3) specified submission periods: March, July or November. All documents related to this process should be presented in triplicate in the form prescribed by CBHE staff. The board staff may request information in addition to that contained in the proposal.*

2. *Approval by the CBHE or its designee of new degree and certificate program proposals submitted by public institutions as well as the formal receipt of new programs from independent institutions are valid for two (2) years following the first fall term after the action. If an institution has not implemented the program by that date, the approval or receiving shall be considered to have lapsed and the program proposal must be resubmitted with updated information.*

3. *Any institution or interested party, that is, a representative from another institution, of the profession, occupation, or specialized academic field, or any individual who, as a potential student or employer, believes him/herself to be affected by the proposed program, may express an opinion to the coordinating board or its designee regarding the evaluation*

or recommendation of any new degree program proposal. This may also occur when an institution or individual wishes to comment on a degree program submitted by another institution. In addition, a formal appeal of a program action may be initiated as provided elsewhere in this rule.

4. Proposal for a new AS transfer degree program.

A. The AS degree is a specialized degree which is intended for transfer into a preprofessional program and is substantively different from the AAS degree. The AAS degree is not intended as a transfer degree into a four (4)-year program and contains courses that are not primarily designed for transfer. Students seeking to transfer this degree will have their transcripts evaluated on a course by course basis.

B. The AS degree should result from careful planning and should constitute an articulation agreement between specific institutions.

C. The primary intent of the AS degree is to provide an alternative to the AA degree in those limited instances when the model general education program included in the AA degree cannot accommodate the demands of a preprofessional program. The AS degree shall be used only in exceptional circumstances when no other remedy is available.

D. The AS degree is to be developed through consultation between sending and receiving institutions on a program-by-program basis. Proposed AS degree programs may be submitted at any time of the year and will be reviewed using a modified program review process. The emphasis of this review will be on the justification for establishing an exception to the prescribed thirty-nine (39)-hour general education core requirement and the resource implications of the proposed agreement for the sending institution. Submission of a staff advisory comment request is not required for proposed programs of this type.

(6) Program Changes. Changes in programs must be submitted to the coordinating board for both informational and review purposes. After considering these changes, the board or its designee may determine that the change in program should be submitted instead as a new program proposal. Program changes should be reported using appropriate forms provided by the CBHE. Program changes that should be submitted include the following:

(A) Program Title Change All revisions or changes in a program name or its nomenclature shall be reported to the CBHA title or nomenclature revision that includes substantive curriculum changes may be deemed tantamount to a new program and be referred back to the institution for resubmission as a new program;

(B) Combination Programs.

1. This category is narrowly defined to include only those programs that result from a mechanical combination of two (2) previously existing programs. Substantive curricular changes shall ordinarily be limited to the elimination of duplicated requirements.

2. The development of interdisciplinary programs and area study programs that utilize the resources of several existing programs shall be handled through the new program approval process.

(C) Single Semester Certificates. A single semester certificate may be added or deleted simply by using a Notice of Changes in Programs form provided by the CBHE. The establishment of a longer program, however, shall be pursued through the procedures established in this rule;

(D) One (1)-year Certificate Programs.

1. A one (1)-year certificate program developed from an approved associate degree program shall be reported as a

program change provided that the program is directly related to the approved associate degree program and consists predominantly of courses included in the associate degree program.

2. A one (1)-year certificate not associated with an approved parent degree program must be submitted as a new program;

(E) Option Addition.

1. The addition of a specialized course of study as a component of an umbrella degree program may be submitted as an option addition program change subject to the limitation that the CBHE or its designee shall make a determination regarding the potential for unnecessary or inappropriate duplication of existing programs. Only in those instances in which duplication is not a problem may the proposed option be implemented.

2. The following general guidelines are used to distinguish a permissible option addition from a proposed new degree program:

A. At the conceptual level an option or emphasis area functions as a component of an umbrella degree program. As such, an option in a specialized topic shall consist of a core area of study in the major plus selected topical courses in the specialty. Typically, the core area of study shall constitute a preponderance of the requirements in the major area of study as measured in the number of required courses or credit hours, but no specific percentage distribution requirement has been established;

B. A proposed option or emphasis area shall be a logical component or extension of the umbrella degree program. One (1) measure of this compatibility—but certainly not the only one—would be the consonance of the proposed addition with the federal CIP taxonomy. For instance, using physics as an example, optics would be an appropriate option (emphasis area) while astrophysics would ordinarily not be acceptable as it is typically viewed as a branch of astronomy rather than physics; and

C. The number of new courses required to implement a new option or emphasis area can also be a relevant consideration. Four (4), five (5) or more new courses in a proposed new option would tend to raise questions about resource commitments and suggest that a new program has been developed;

(F) Inactive Status for Existing Programs.

1. Programs placed on inactive status will essentially be suspended for a specified period not to exceed five (5) years. Students in the program at the time this status is adopted shall be permitted to conclude their course of study if they have no more than two (2) years of course work remaining, but no new students may be admitted to the program. Programs designated as inactive will be so noted on institutional program inventories.

2. At the conclusion of the designated inactive period—not to exceed five (5) years—the institution must review the program's status and may either delete it or reactivate it.

3. In the event the institution chooses to reactivate the program, the institution shall provide the coordinating board satisfactory evidence that the resources necessary for the program are available and must establish performance goals for the program that are also acceptable to the coordinating board; and

(G) Deletion and Consolidation of Programs. Institutions must submit standard program change information whenever a program or option is deleted. This same provision applies whenever two (2) or more programs or options are to be consolidated into one (1) or more new offerings.]

[[7]](6) Use of Consultants.

(A) In addition to evaluating written proposals, the board or its designee, in some circumstances, may use the services of consultants. It is anticipated that this procedure will be used *[infrequently]* **primarily for comprehensive reviews.**

(B) These consultants *[shall]* **must** be individuals who are mutually acceptable to the board and to the **public** institution whose program is under consideration. Both the commissioner and the **public** institution may recommend consultants, but the ultimate selection of the consultant *[shall]* **must** be agreeable to both.

(C) Services of consultants will be paid for by the **public** institution whose program is pending.

(D) Consultants may be used in the following circumstances:

1. At the request of either the commissioner or the **public** institution pending an unfavorable recommendation by *[the coordinating board]* **department** staff;

2. For some health-related professions or high technology programs whenever clinical facilities, laboratory facilities, equipment, or other aspects of the program need professional evaluation; or

3. In instances in which a judgment is difficult to make without the evaluation of professionally qualified external consultants.

[(8)](7) Programs Reviewed Jointly by the Coordinating Board for Higher Education and the Department of Elementary and Secondary Education.

(A) A *[n]* **public** institution requesting financial reimbursement for a new program from vocational/technical funds administered by the Department of Elementary and Secondary Education must submit at the same time *[two (2) copies]* **a copy** of the proposal in the CBHE's format to the Division of Career and Adult Education of the Department of Elementary and Secondary Education in accordance with the instructions of that office. *[Because independent institutions are not eligible for reimbursement under this program, this section does not apply to independent institutions.]*

(B) The coordinating board and the Department of Elementary and Secondary Education concur on the following procedures and understandings for effecting cooperation between the two (2) agencies in the exercise of their respective responsibilities regarding the development of vocational/technical programs in Missouri colleges and universities:

1. The responsibilities of the Department of Elementary and Secondary Education to approve courses of instruction for vocational/technical financial reimbursement and of the *[coordinating board]* **CBHE** to approve new degree and certificate programs are independent responsibilities and are not contingent one upon the other. However, as a general policy the Department of Elementary and Secondary Education will not approve financial reimbursement requests which are components of degree or certificate programs not approved by the coordinating board;

[2. In order to avoid duplication of effort by institutions, the Department of Elementary and Secondary Education will employ the coordinating board's proposal format for submission of new program proposals as its instrument for fiscal reimbursement requests;]

[3.]2. *[Coordinating Board for Higher Education]* **CBHE** staff will notify Department of Elementary and Secondary Education staff of the development of any vocational/technical program, and members of both staffs will confer on all vocational/technical degree and certificate programs submitted to the coordinating board; and

[4.]3. The Division of Career and Adult Education of the Department of Elementary and Secondary Education will receive notification of the commissioner's actions on all vocational/technical program proposals.

[(9)](8) Appeal Procedure. In the event of an appeal of a program review action for *[either]* a public *[or independent]* institution, the following procedures *[shall be followed]* **apply**:

(A) Any of the following parties may initiate an appeal of a program action decision:

1. The **public** institution submitting the original proposal;

2. Any Missouri higher education institution that believes its interests are adversely affected by the program decision; or

3. Any member of the *[Coordinating Board for Higher Education]* **CBHE**, in the event the original decision was made by the board's designee;

(B) An appeal originating with a higher education institution must be signed by the chief executive officer of the institution;

(C) A letter of intent to appeal must be received by the commissioner *[of higher education]* within thirty (30) days of receipt of the official notice of the program decision. If the appeal is initiated by a party other than the **public** institution that proposed the program, a copy of the intent to appeal letter and all other subsequent documentation must be sent to the sponsoring institution;

(D) The new program may not be implemented while an appeal is pending;

(E) Within fourteen (14) days after a letter of intent to appeal has been submitted, the appealing party must submit its full rationale in support of the appeal to the commissioner and to any affected institutions. This rationale should summarize the appellant's justification for a review of the program decision and should include any relevant supporting evidence;

(F) This rationale and the responses of the commissioner and any affected institutions will be placed on the agenda of the next meeting of the *[Coordinating Board for Higher Education]* **CBHE**, provided that the next meeting is scheduled at least fourteen (14) days after receipt of the rationale. If *[this criterion is not satisfied]* **the rationale is received less than fourteen (14) days before the next meeting**, the request for an appeal will be heard by the *[board]* **CBHE** at its next regularly scheduled meeting;

(G) *[If a majority of the Coordinating Board for Higher Education agrees that an appeal initiated by an institution should be heard, the matter will be referred to the CBHE committee on academic and library affairs]* **The CBHE chair will refer the matter to a relevant committee of the CBHE.** A public meeting of the committee will be scheduled at which time testimony will be presented by all interested parties, and the committee *[shall]* **will** make its determination;

(H) In those instances when a member of the *[coordinating board]* **CBHE** has initiated a review of a decision by the board's designee, the chair *[man]* of the board *[shall]* **will** receive copies of all relevant documents. Provided that a majority of the board agrees that an appeal should be heard, the board may decide either to refer the matter to *[the]* **a relevant committee [on academic and library affairs or to hear the appeal itself] of the CBHE.** If the matter is heard by the committee, the same procedures *[shall]* **will** apply as if the appeal were initiated by an institution. If the matter is heard directly by the board, the chair *[man]* of the board *[shall]* **will** establish the appropriate procedural guidelines; **and**

(I) All decisions of the body hearing the appeal, whether the full *[coordinating board]* **CBHE** or its committee *[on academic and library affairs, shall, will]* be final; **and**].

[(J)] *This section on appeal procedures is intended to be applicable to both public and independent institutions, but no provision of this section shall supersede the general principle that decisions or recommendations by the Coordinating Board for Higher Education or the commissioner of higher education regarding programs submitted by independent institutions shall be recommendatory only.]*

[(10)](9) General Review Criteria for New Degree and Certificate Programs.

(A) Mission and Planning Priorities.

1. The proposed new program must be consistent with the institutional mission, as well as the principal planning priorities of the **public** institution, as set forth in the **public** institution's approved plan or plan update *[in the case of public institutions or the institutional mission statement in the case of independent*

institutions].

2. The *[coordinating board shall]* CBHE will determine if proposed programs are consistent with a public institution's plan or plan update as approved by the *[coordinating board]* CBHE. Except in unusual circumstances, only those proposed new programs submitted by a public institution that are consistent with the institution's mission statement and, when appropriate, anticipated in its approved institutional plan, *[shall]* will be eligible for approval and implementation.

(B) Need for the Proposed Program.

1. *[There]* Public institutions shall *[be a]* clearly demonstrate[d] and *[well-/document/ed]* demand and/or need for the program in terms of meeting present and future needs of the locale and the state, although it is recognized that for program approval purposes state needs are a part of broader national needs. Three (3) kinds of needs may be identified—

A. Societal needs;

B. Occupational needs relative to upgrading vocational/technical skills or meeting labor market requirements; and

C. Student needs for a program.

2. Some programs may be desirable on the basis of their cultural contribution or social value or potential to serve student interests independent of labor market or demand considerations. However, in these instances the societal and student need for the program must be clearly demonstrated by the public institution submitting the proposal.

3. Public *[institutions proposing new programs must present data projecting employment and student demands and availability of openings in the labor market to]* at the routine level must certify that employment and student demands exist, are backed by compelling data, and will be served by the new program. The kinds of information and data *[submitted]* used will vary somewhat with the type of program proposed but may include the following: personnel and employment projections prepared by the Bureau of Labor Statistics and the Missouri Occupational Information Coordinating Committee (MOICC) as well as professional and trade associations; surveys of potential employers, including numbers of anticipated vacancies and training requirements; and surveys of potential student interest.

4. Adequate data *[shall be provided to]* should support projections for the number of students who are expected to enter the program. Program enrollment *[shall]* should be sufficient to ensure a quality educational experience *[as well as an]* and make efficient *[utilization]* use of resources.

5. As an additional indicator of need, the public institution shall *[clearly detail]* explain how program success will be defined and measured, particularly if that definition includes measures in addition to the conferral of a degree or certificate.

6. Determination of need for a new program will be based in part upon an assessment of the function to be served by the program and the availability of alternative sources of education in a given service area. Availability of spaces in the same or similar programs in all institutions in the state offering postsecondary programs will be taken into account, as will possibilities for interinstitutional arrangements, including contracting as provided by statute.

(C) Duplication of the Proposed Program.

1. A public institution's proposed program shall not be unnecessarily duplicative of *[those of]* other Missouri institutions' programs. Ordinarily, proposed programs in basic liberal arts and sciences at the baccalaureate level would not be considered unnecessarily duplicative, provided sufficient student demand can be demonstrated. Unnecessary duplication is a more specific concern in graduate, technical, and professional programs which meet special labor market needs.

[2. The questions of how a proposed program meets an institution's local and state service area needs and how it articulates with appropriate baccalaureate or graduate programs shall also be addressed (In this context it is under-

stood that some programs, for example, the AAS, are designed to be terminal in character and are not ordinarily expected to articulate with more advanced programs.)]

[3.]2. [Factors salient to the duplication issue include,] Unnecessary or inappropriate duplication will be determined by assessing the following factors in descending order of priority~~/,~~: the relevance of existing programming; the availability of alternative educational delivery systems; the extent of student demand; state or regional work force demand; and access considerations such as geographic availability, student population served, and cost of instruction.

3. No public institution other than the University of Missouri and its campuses may offer a Ph.D. or professional practice doctorate (a.k.a. "first-professional degree") without CBHE approval pursuant to subsection (4)(C) of this rule.

A. All first-professional degree programs are closely regulated by recognized professional and specialized accrediting agencies. Some first-professional degrees require a prior degree, but this is not true of all. First-professional degrees include the following:

(I) Chiropractic (D.C. or D.C.M.)

(II) Dentistry (D.D.S. or D.M.D.)

(III) Law (L.L.B., J.D.)

(IV) Medicine (M.D.)

(V) Optometry (O.D.)

(VI) Osteopathic Medicine (D.O.)

(VII) Pharmacy (Pharm.D.)

(VIII) Podiatry (D.P.M., D.P., or Pod.D.)

(IX) Theology (M.Div., M.H.L., B.D., or Ordination)

(X) Veterinary Medicine (D.V.M.)

B. The Ph.D. in any discipline is generally recognized as a research degree, typically requiring completion of original research or evidence of artistic accomplishment. Ph.D. programs require unique faculty, student/faculty ratios, assigned teaching loads, and infrastructure and financial support.

[4. Determination of need for a new program will be based in part upon an assessment of the function to be served by the program and the availability of alternative sources of education in a given service area. Availability of spaces in the same or similar programs in all institutions in the state offering postsecondary programs will be taken into account, as will possibilities for interinstitutional arrangements, including contracting as provided by statute.]

(D) Program Structure.

1. Existing programs can be strengthened and enriched when appropriate new courses and certificate or degree programs are added to the curriculum. A proposed program should be based on existing strengths of the public institution rather than be composed entirely of new courses. Off-campus degree programs must be based on existing on-campus degree programs.

A. Normally, graduate programs should be built upon strong baccalaureate programs which can support advanced study through basic library holdings, faculty resources, and appropriate research facilities and funds. It is, however, recognized that some graduate programs in universities and medical schools do not require supporting undergraduate baccalaureate majors in that field.

B. New public institutions in the process of being established may also be considered exceptions to this general expectation, but special procedures have been established in this rule to accommodate the developing institution.

2. There *[shall]* will be a carefully planned and systematic program of study for the proposed program which is clear and comprehensive. The structure of a new program *[shall]* must take into account, and be demonstrably consistent with, program objectives and intended student learning outcomes.

A. The linkage between program requirements and anticipated learning outcomes shall be delineated. Required courses in the major *[shall]* must not be excessive and should be consistent with

customary expectations for the type of degree proposed.

B. The curriculum of the proposed program *[shall]* **must** reflect the requirements of any accrediting or certifying body if the **public** institution elects to apply for accreditation or certification. (This statement is not intended to imply that specialized accreditation should be an institutional goal.)

C. **Unless necessary for accreditation or licensure, new baccalaureate degrees should consist of no more than one hundred twenty (120) semester credit hours and new associate degrees should consist of no more than sixty (60) semester credit hours.**

3. Innovative programs of study shall also contain an orderly and identifiable sequence of education experiences that lead to a recognizable goal.

A. The awarding of credit for any experiential learning, credit by examination, off-campus courses, etc., shall be consistent with both established institutional and *[coordinating board]* CBHE policies. The requirements for off-campus programs *[shall]* **must** be fully comparable to those for similar on-campus programs. If these requirements are not the case for the proposed program, the rationale for the difference must be clearly explained.

B. The policies and procedures for granting experiential credit and/or credit by examination (including the maximum number of such credit hours which are applicable to a specific degree program and the minimum scores which are acceptable) *[shall]* **must** be clearly specified in written guidelines available to the student. The maximum number of experiential credit hours applicable to a specific degree program *[shall]* **must** be the same for students enrolled at off-campus locations as for students enrolled on-campus.

4. In general, courses offered for credit off-campus *[shall]* **must** be part of the regular catalogue offerings of the **public** institution and *[shall]* **must** be applicable to programs in the same manner as courses taken on-campus. Special courses developed solely for off-campus teaching *[shall]* **must** be limited and *[shall be]* consistent with the mission of the **public** institution. The standards for awarding credit to students enrolled at off-campus locations *[shall]* **must** be the same as the standards applied to students enrolled on campus.

5. Each **public** institution's policy concerning residency for academic study purposes (as distinct from fee level) *[shall]* **must** be stated clearly regarding the number of credit hours applicable to a degree program which must be earned in-residence on its campus and *[shall]* **must** explicitly define in-residence.

(E) Faculty Resources. Faculty resources *[shall]* **must** be appropriate for the program, given the sponsoring **public** institution's mission and the character of the program to be developed.

1. The minimum educational attainment of the faculty *[shall]* **must** be the appropriate degree and/or occupational or other equivalent experiences commensurate with the degree level of the proposed program. While the doctorate, in most instances, is the appropriate terminal degree for baccalaureate and graduate programs, the Master of Fine Arts (MFA) or a similar degree is often considered a terminal degree. If accreditation is a desired goal of the program, the number of terminal degree holders *[shall]* **must** meet the minimum requirements of the appropriate accrediting association.

2. Adjunct faculty are an important and necessary component of some programs, particularly those programs that require a high degree of vocational/technical competence. However, programs *[shall]* **must** involve credentialed full-time faculty in teaching, program development, and student services. If a program will involve more than fifty percent (50%) adjunct faculty, the rationale for the use of adjunct faculty *[shall]* **must** be documented and approved by the coordinating board or its designee.

3. Adjunct faculty, when utilized, *[shall]* **must** possess the same or equivalent qualifications as the regular faculty of the **public** institution and *[shall]* be approved by the academic unit through which the credit is offered. The responsibilities of adjunct faculty *[shall]* **will** be specified in such a manner that their involvement in program

development and academic advising is assured, or that these activities are provided by other appropriate means.

4. Expected faculty workloads *[shall]* **must** be appropriate and consistent with good educational practice and expressed in student credit hours per full-time equivalent faculty member in the administrative unit that will support the proposed program. This information, of course, must be evaluated in the context of the sponsoring institution's mission, the mission of the proposed program, and the character of the discipline from which the proposed program is an outgrowth.

(F) Library Resources.

1. Qualitative and quantitative factors of library resources *[shall]* **must** be appropriate for the proposed program, given the sponsoring **public** institution's mission and the character of the program to be developed. Books, periodicals, microfilms, microfiche, monographs, and other collections *[shall]* **must** be sufficient in number, quality, and currency to serve the program. Adequacy of the library personnel and of facilities to service the proposed program in terms of students and faculty will be considered. While some technical programs may not demand the same type or extent of holdings and services conventional arts and science programs do, these factors must be adequate.

2. Access to interlibrary loans and to libraries at other institutions or in other cities *[shall]* **will** be indicated. Interlibrary loans and reciprocal loan privileges at local libraries may constitute valuable resources for the program. However, within this framework, adequate library material *[shall]* **must** be available at the **public** institution which proposes the program. If the program is to be taught off-campus, access to adequate library resources *[shall]* **must** be provided.

(G) Physical Facilities and Instructional Equipment. **The public institution shall provide** *[P]physical facilities and instructional equipment [shall be] adequate to support the program[.] and [S]space[s shall be provided] for classrooms and for staff and faculty offices. Laboratories for studies in the technologies and sciences [shall] must be designed to provide maximum utilization of facilities, materials, and equipment[. Some courses require laboratory facilities], which may include specialized equipment such as computer terminals and audiovisual aids, or other special resources. The public institution offering these courses off-campus [shall] must assure that appropriate support requirements are met.*

(H) Administration and Evaluation.

1. Administration of the proposed programs *[shall]* **should** not be unduly cumbersome or costly[.] **and** *[I]ideally, [the program should] fit into the public institution's current administrative structure [of the institution].* If administrative changes are required, they *[shall]* **should** be consistent with the organization of the **public** institution as a whole and necessitate a minimum of additional expense in terms of personnel and office space.

2. Proposals for jointly sponsored programs *[shall]* **should** include *[provisions for]* adequate plans for cooperative administration.

3. Each **public** institution shall set forth not only the administrative organization but also the instructional supervision and evaluation procedures for the program. These procedures *[shall]* **must** include evaluation of courses and faculty by students, administrators, and departmental personnel. Curriculum review procedures established by each **public** institution for its program offerings *[shall]* **must** include standards and guidelines for the assessment of student outcomes as defined for the program and consistent with the institutional mission.

[4. The institution shall establish clearly defined performance goals for the new program to be achieved during a stipulated implementation period. The institution may revise its performance goals for the new program at any time during the designated implementation period with the concurrence of the CBHE staff.]

5. *The institution shall define a review process with the*

concurrence of coordinating board staff to assess the program's development. In the event a new program fails to develop satisfactorily in the allotted period as determined by the commissioner, the status of the new program shall be evaluated. As a result of this review, approval may be continued with or without further stipulations, or program authorization may be withdrawn.]

[6.]4. In the event that program authorization is withdrawn or approval is denied, if the sponsoring public institution chooses to continue the new program rather than terminate it, the resources associated with the program *[shall]* will be withdrawn from the public institution's funding base for the purpose of developing future state appropriation requests[—].

[7. Paragraphs(10)(H)4. —6. of this rule are not applicable to independent institutions.]

(I) Finances.

1. Suitable financing for initiating proposed programs must be available. Programs should be financed with fees from students new to the institution, funds that have been reallocated from institutional sources or grants, contracts or sources other than normal state appropriations for higher education.

2. In those circumstances for which one- (1-)/- time or limited duration funds are an integral component of the financing arrangements for a new program, the institution must also define a transition plan for the period when the one- (1-)/- time or limited duration funds cease to be available.

3. The proposed program may require phasing-out of some existing program(s) to reallocate institutional resources for new programs that are a logical outgrowth of existing public institutional strengths and consistent with the approved public institutional plan or plan update.

4. Ordinarily, approval will be extended only for those programs that meet these requirements unless the sponsoring public institution specifically requests additional state funds for program implementation. In this event, approval *[shall]* will be conditional on actual receipt of these funds through the legislative process.

[5. This subsection on finances is not applicable to independent institutions.]

AUTHORITY: section[s 173.005(2), RSMo (1986) and] 173.030, RSMo [(Supp. 1988)] 2016, and section 173.055(2), RSMo Supp. 2018. Original rule filed Feb. 13, 1979, effective June 18, 1979. Rescinded and readopted: Filed July 18, 1989, effective Oct. 15, 1989. Amended: Filed Oct. 22, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may submit a statement in support of or in opposition to this proposed amendment to the attention of Academic Affairs, Missouri Department of Higher Education, PO Box 1469, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 4—Licenses**

PROPOSED AMENDMENT

11 CSR 45-4.420 Occupational License. The commission is amend-

ing sections (2), (3), and (4).

PURPOSE: This amendment corrects references to the type of licensee referenced in section (2), and removes obsolete language from sections (3) and (4).

(2) Upon the filing of an application for an occupational license, the director may issue a temporary occupational license to allow an applicant to perform the function for which the applicant has applied. The director may withdraw or suspend this temporary occupational license by withdrawing the holder's occupational license badge upon a determination to seek denial of licensure by the commission and on so doing report this action to the commission, the Class *[A]* B licensee who employed the applicant, and the applicant.

(3) Upon issuance of an occupational license to applicant, applicant shall receive *[a partially completed]* an occupational license badge from the commission.

(4) Whenever an occupational license badge *[shall be]* is lost or destroyed, a duplicate occupational license badge in lieu of the lost or destroyed occupational license badge will be issued by the commission. The fee for a replacement occupational license badge is fifteen dollars (\$15). Application for a duplicate occupational license badge shall be by affidavit of the licensee which shall set forth—

AUTHORITY: sections 313.004, *[and 313.850, RSMo 2000, and section] 313.800, 313.805, and 313.807, RSMo [Supp. 2013] 2016.* Original rule filed May 13, 1998, effective Oct. 30, 1998. Amended: Filed Dec. 7, 2001, effective June 30, 2002. Amended: Filed Dec. 3, 2007, effective May 30, 2008. Amended: Filed Dec. 5, 2013, effective Aug. 30, 2014. Amended: Filed Nov. 1, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. A public hearing is scheduled for Tuesday, January 8, 2019, at 10:a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.

**Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 7—Security and Surveillance**

PROPOSED AMENDMENT

11 CSR 45-7.130 Nongambling Hours. The commission is amending section (1) and renumbering subsection (1)(B) as section (2).

PURPOSE: This amendment resolves a conflict with 11 CSR 45-9.113 regarding the surveillance requirement during nongambling hours.

[(1) Surveillance will be required during nongambling hours as follows:]

[(A)](1) [Cleanup and Removal Time. Anytime cleanup operations or money removal is being conducted in the casino

area, a)At least **two** (2) trained surveillance operators must be on duty [and present] in the casino surveillance room[; and] **actively monitoring activities during nongambling hours when no drops and counts are being conducted.**

[(B)](2) [Locked-Down Mode.] Anytime the casino is closed and in a locked-down mode, sufficient surveillance coverage as approved by the commission must be conducted to monitor and record the casino, in general, so that security integrity is maintained. [During this period it is not required that a trained surveillance person be present.]

AUTHORITY: sections 313.004, 313.800, 313.805, and 313.824, RSMo [2000] 2016. Emergency rule filed Sept. 1, 1993, effective Sept. 20, 1993, expired Jan. 17, 1994. Emergency rule filed Jan. 5, 1994, effective Jan. 18, 1994, expired Jan. 30, 1994. Original rule filed Sept. 1, 1993, effective Jan. 31, 1994. Amended: Filed Feb. 26, 2001, effective Sept. 30, 2001. Amended: Filed Nov. 1, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. A public hearing is scheduled for Tuesday, January 8, 2019, at 10:a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.

Title 11—DEPARTMENT OF PUBLIC SAFETY Division 45—Missouri Gaming Commission Chapter 9—Internal Control System

PROPOSED AMENDMENT

11 CSR 45-9.102 Minimum Internal Control Standards (MICS)—Chapter B. The commission is amending section (1).

PURPOSE: This amendment changes the internal controls for Chapter B of the **Minimum Internal Control Standards** by clarifying requirements for sensitive keys.

(1) The commission shall adopt and publish minimum standards for internal control procedures that in the commission's opinion satisfy 11 CSR 45-9.020, as set forth in **Minimum Internal Control Standards (MICS)** Chapter B—Key Controls, which has been incorporated by reference herein, as published by the Missouri Gaming Commission, 3417 Knipp Dr., PO Box 1847, Jefferson City, MO 65102. Chapter B does not incorporate any subsequent amendments or additions as adopted by the commission on [February 23, 2011] **October 31, 2018.**

AUTHORITY: sections 313.004, [RSMo 2000 and sections] 313.800, and 313.805, RSMo [Supp. 2010] 2016. Original rule filed Oct. 22, 2010, effective June 30, 2011. Amended: Filed Nov. 1, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. A public hearing is scheduled for Tuesday, January 8, 2019, at 10:a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.

Title 11—DEPARTMENT OF PUBLIC SAFETY Division 45—Missouri Gaming Commission Chapter 9—Internal Control System

PROPOSED AMENDMENT

11 CSR 45-9.106 Minimum Internal Control Standards (MICS)—Chapter F. The commission is amending section (1).

PURPOSE: This amendment changes the internal controls for Chapter F of the **Minimum Internal Control Standards** by removing unnecessary language and lessening staffing requirements for deck inspections.

(1) The commission shall adopt and publish minimum standards for internal control procedures that in the commission's opinion satisfy 11 CSR 45-9.020, as set forth in **Minimum Internal Control Standards (MICS)** Chapter F—Poker Rooms, which has been incorporated by reference herein, as published by the Missouri Gaming Commission, 3417 Knipp Dr., PO Box 1847, Jefferson City, MO 65102. Chapter F does not incorporate any subsequent amendments or additions as adopted by the commission on [July 30, 2014] **October 31, 2018.**

AUTHORITY: sections 313.004, [RSMo 2000, and sections] 313.800, 313.805, 313.812, 313.817, and 313.830, RSMo [Supp. 2014] 2016. Original rule filed Jan. 26, 2012, effective Aug. 30, 2012. Amended: Filed Oct. 25, 2012, effective June 30, 2013. Amended: Filed March 28, 2013, effective Dec. 30, 2013. Amended: Filed July 31, 2014, effective Feb. 28, 2015. Amended: Filed Nov. 1, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. A public hearing is scheduled for Tuesday, January 8, 2019, at 10:a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.

Title 11—DEPARTMENT OF PUBLIC SAFETY Division 45—Missouri Gaming Commission Chapter 9—Internal Control System

PROPOSED AMENDMENT

11 CSR 45-9.109 Minimum Internal Control Standards (MICS)—Chapter I. The commission is amending section (1).

PURPOSE: This amendment changes the internal controls for Chapter I of the *Minimum Internal Control Standards* by clarifying procedures for progressive jackpot meters and issuing player cards.

(1) The commission shall adopt and publish minimum standards for internal control procedures that in the commission's opinion satisfy 11 CSR 45-9.020, as set forth in *Minimum Internal Control Standards* (MICS) Chapter I—Casino Accounting, which has been incorporated by reference herein, as published by the Missouri Gaming Commission, 3417 Knipp Dr., PO Box 1847, Jefferson City, MO 65102. Chapter I does not incorporate any subsequent amendments or additions as adopted by the commission on [October 29, 2014] **October 31, 2018**.

AUTHORITY: sections 313.004, [RSMo 2000, and sections] 313.800, 313.805, 313.812, 313.817, and 313.830, RSMo [Supp. 2014] **2016**. Emergency rule filed July 31, 2014, effective Aug. 28, 2014, expired Feb. 26, 2015. Original rule filed July 31, 2014, effective Feb. 28, 2015. Amended: Filed Nov. 1, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. A public hearing is scheduled for Tuesday, January 8, 2019, at 10:a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.

**Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 9—Internal Control System**

PROPOSED AMENDMENT

11 CSR 45-9.116 Minimum Internal Control Standards (MICS)—Chapter P. The commission is amending section (1).

PURPOSE: This amendment changes the internal controls for Chapter P of the *Minimum Internal Control Standards* by clarifying procedures for determining if an individual is an excluded person.

(1) The commission shall adopt and publish minimum standards for internal control procedures that in the commission's opinion satisfy 11 CSR 45-9.020, as set forth in *Minimum Internal Control Standards* (MICS) Chapter P—Excluded Persons, which has been incorporated by reference herein, as published by the Missouri Gaming Commission, 3417 Knipp Dr., PO Box 1847, Jefferson City, MO 65102. Chapter P does not incorporate any subsequent amendments or additions as adopted by the commission on [July 30, 2014] **October 31, 2018**.

AUTHORITY: sections 313.004, [RSMo 2000, and sections] 313.800, 313.805, 313.812, 313.817, and 313.830, RSMo [Supp. 2014] **2016**. Emergency rule filed July 31, 2014, effective Aug. 28, 2014, expired Feb. 26, 2015. Original rule filed July 31, 2014, effective Feb. 28, 2015. Amended: Filed Nov. 1, 2018.

PUBLIC COST: This proposed amendment will not cost state agen-

cies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. A public hearing is scheduled for Tuesday, January 8, 2019, at 10:a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.

**Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 9—Internal Control System**

PROPOSED AMENDMENT

11 CSR 45-9.117 Minimum Internal Control Standards (MICS)—Chapter Q. The commission is amending section (1).

PURPOSE: This amendment changes the internal controls for Chapter Q of the *Minimum Internal Control Standards* by clarifying procedures for determining if an individual is a disassociated person.

(1) The commission shall adopt and publish minimum standards for internal control procedures that in the commission's opinion satisfy 11 CSR 45-9.020, as set forth in *Minimum Internal Control Standards* (MICS) Chapter Q—Disassociated Persons, which has been incorporated by reference herein, as published by the Missouri Gaming Commission, 3417 Knipp Dr., PO Box 1847, Jefferson City, MO 65102. Chapter Q does not incorporate any subsequent amendments or additions as adopted by the commission on [November 4, 2015] **October 31, 2018**.

AUTHORITY: sections 313.004, [RSMo 2000, sections] 313.800, 313.805, 313.812, 313.813, 313.817, and 313.830, [RSMo Supp. 2014, and sections 313.805 and 313.813,] RSMo [Supp. 2013] **2016**. Original rule filed Aug. 25, 2011, effective March 30, 2012. Emergency amendment filed July 31, 2014, effective Aug. 28, 2014, expired Feb. 26, 2015. Amended: Filed July 31, 2014, effective Feb. 28, 2015. Amended: Filed Nov. 4, 2015, effective June 30, 2016. Amended: Filed Nov. 1, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. A public hearing is scheduled for Tuesday, January 8, 2019, at 10:a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 30—Bingo

PROPOSED RESCISSION

11 CSR 45-30.020 Advertising. This rule clarified the amount of money licensees could use for advertising bingo operations pursuant to 313.040(9), RSMo.

PURPOSE: This rule is being rescinded to be consistent with the statutory change.

AUTHORITY: section 313.040, RSMo Supp. 2010 and section 313.065, RSMo 2000. Emergency rule filed June 21, 1994, effective July 1, 1994, expired Oct. 28, 1994. Emergency rule filed Oct. 19, 1994, effective Oct. 29, 1994, expired Feb. 25, 1995. Original rule filed July 11, 1994, effective Jan. 29, 1995. Amended: Filed Dec. 14, 1998, effective July 30, 1999. Amended: Filed July 28, 2010, effective Jan. 30, 2011. Rescinded: Filed Nov. 1, 2018.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. A public hearing is scheduled for Tuesday, January 8, 2019, at 10:a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 40—Fantasy Sports Contests

PROPOSED AMENDMENT

11 CSR 45-40.030 Commission Approval of Procedures. The commission is deleting section (1), amending and renumbering sections (2) and (3), and renumbering each section thereafter.

PURPOSE: This amendment removes duplicative language and gives additional clarification in regard to submitting procedures.

[(1)] Prior to operating in Missouri, each applicant for a Fantasy Sports Contest Operator (FSCO) License shall submit procedures to the commission that—

(A) Prevent unauthorized withdrawals from a registered player's account by the licensed operator or others;

(B) Make clear that funds in a registered player's account are not the property of the licensed operator and are not available to the licensed operator's creditors;

(C) Segregate player funds from operational funds;

(D) Maintain a reserve in the form of cash or cash equivalents in the amount of the deposits made to the accounts of fantasy sports contest players for the benefit and protection of the funds held in such accounts;

(E) Ensure any prize won by a registered player from participating in a fantasy sports contest is deposited into the

registered player's account within forty-eight (48) hours of winning the prize;

(F) Ensure registered players can withdraw the funds maintained in their individual accounts, whether such accounts are open or closed, within five (5) business days of the request being made, unless the licensed operator believes in good faith that the registered player engaged in either fraudulent conduct or other conduct that would put the licensed operator in violation of sections 313.900 to 313.955, RSMo, in which case the licensed operator may decline to honor the request for withdrawal for a reasonable investigatory period until its investigation is resolved if it provides notice of the nature of the investigation to the registered player. For the purposes of this provision, a request for withdrawal will be considered honored if it is processed by the licensed operator but delayed by a payment processor, credit card issuer, or by the custodian of a financial account;

(G) Allow a registered player to permanently close their account at any time for any reason; and

(H) Offer registered players access to their play history and account details.]

[(2)] (1) For all procedures required by statute to be approved by the commission [E]ach applicant shall submit the written description of its procedures and all supporting documents designed to satisfy the requirements [of section (1)] of [this rule] **Chapter 313, RSMo** to the commission with the initial application, unless otherwise directed by the commission.

[(3)](2) The commission shall review each submission required by [section (2) of this rule and] Chapter 313, RSMo, and shall determine [whether it conforms to the requirements of section (1) of this rule and] whether the procedures submitted satisfy the requirements. If the commission finds any insufficiencies, they shall be specified in writing to the licensee, who shall make appropriate alterations. No FSCO license shall be issued unless and until the procedures are approved by the commission.

[(4)](3) Once approved, no licensed operator shall alter its procedures unless and until the change is approved by the commission.

[(5)](4) Each licensed operator shall submit to the commission any change to the approved procedures no less than fifteen (15) days prior to the planned implementation date of the change. The proposed change to the procedures shall be approved or disapproved by the commission. Upon approval, the change may be implemented. If the change is disapproved, the licensed operator shall not implement the change.

[(6)](5) If at any time the commission determines that a licensed operator's procedures are inadequate or do not comply with the requirements of this chapter or Chapter 313, RSMo, the commission shall notify the licensed operator in writing. Within fifteen (15) days after receiving the notification, the licensed operator shall amend its procedures accordingly and shall submit a copy of the procedures, as amended, and a description of any other remedial measures taken.

[(7)](6) If a licensed operator plans to disseminate the List of Disassociated Persons (DAP List), the operator shall submit to the commission a plan for the dissemination of the information regarding persons placed on the DAP List, as well as persons who have been removed from the DAP List. The plan shall be designed to safeguard, as best as is reasonably possible, the confidentiality of the information but shall include dissemination to at least the personnel responsible for removing a person on the DAP List from all individually targeted advertising or marketing. Licensed operators may not disclose the name of, or any information about, a person who has been placed on or removed from the DAP List to anyone other than

employees and agents of the licensed operator whose duties and functions require access to the information. The plan must be approved by the commission prior to disseminating the information. All information disclosed to any licensed operator regarding anyone placed on or removed from the DAP List shall be deemed a closed record; however, the information may be disclosed as authorized by the individual seeking placement on the DAP List, by law, and through the provisions contained in 11 CSR 45-17.

AUTHORITY: sections 313.915, 313.920, 313.950, and 313.955, RSMo 2016. Emergency rule filed Aug. 29, 2016, effective Sept. 8, 2016, expired March 6, 2017. Original rule filed Aug. 29, 2016, effective March 30, 2017. Amended: Filed Nov. 1, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. A public hearing is scheduled for Tuesday, January 8, 2019, at 10:a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.

**Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 23—Motor Vehicle**

PROPOSED AMENDMENT

12 CSR 10-23.100 Special License Plates. The department is amending sections (1)–(2) and (5)–(8), deleting section (11), and renumbering as necessary.

PURPOSE: This rule is being amended to add local and beyond local 24,000 lb. special license plate categories, update an outdated statutory reference, and remove unnecessary language.

(1) For the purpose of this rule, “special license plates” *[shall]* includes all personalized, military, collegiate, helping schools, and special organizational license plates that contain letters and/or numbers and may include one apostrophe (’), one space, or one dash (—).

(2) All special license plates are available in the following plate categories—

(I) Local and Beyond Local 24;

[(I)](J) Shuttle Bus—regular personalized plates only;

[(J)](K) Van Pool—regular personalized plates only; and

[(K)](L) Historic—regular personalized plates only.

(5) Special license plates *[shall]* **will** not be transferred from one (1) owner to another unless provided by law, except that the holder of a special plate may follow the procedures established by the director in order to display his/her special plate on a vehicle leased by the holder after approval by the director; and they *[shall]* **will** not be transferred from one (1) vehicle category to another. This includes any request for transfer by gift, trust, will, or judicial proceeding.

(6) The director of revenue *[shall]* reserves the right to approve or disapprove any request for special license plates or the transfer of license plates from one (1) vehicle to another in the same category.

(7) *[The month of expiration on all special license plates for motorcycles and motortricycles will be April of each year.]* Special license plates issued to members of the United States Congress, Missouri State Senate, and Missouri House of Representatives; honorary consulars; and the following statewide elected officials: governor, lieutenant governor, secretary of state, state auditor, state treasurer, and attorney general, which are issued in accordance with section *[301.144]* **301.453**, RSMo, will expire in January of each year. *[The month of expiration on all other special license plates issued or renewed prior to January 1, 2009, shall be staggered. Special license plates issued or renewed on or after January 1, 2009, shall expire as detailed in the chart below.]* **Passenger, RV, 6,000 and 12,000 lb. Commercial Motor Vehicle (CMV), Shuttle Bus, Van Pool, and Personalized Historic special license plates will expire in July of each year.** Registrations for special license plates will be issued for a minimum of six (6) months except as otherwise determined by the director. Applicants who purchase a biennial registration will extend the registration another year with the total registration not to exceed thirty (30) months.

<i>SPECIAL LICENSE PLATE CATEGORY</i>	<i>EXPIRATION MONTH</i>
<i>Governor, Lieutenant Governor, Secretary of State, State Auditor, State Treasurer, Attorney General, United States Congress, Missouri State Senate, Missouri House of Representatives, and Honorary Consulars</i>	<i>January</i>
<i>Passenger, RV, 6,000 and 12,000 lb. Commercial Motor Vehicle (CMV), Shuttle Bus, Van Pool, Personalized Historic</i>	<i>July</i>
<i>Motorcycle/tricycle</i>	<i>April</i>
<i>18,000 lb. and above CMV</i>	<i>December]</i>

(8) Initial applications for special license plates *[shall]* **will** be made on *[Form 1716, Application For Missouri Personalized And Special License Plates, or Form 4601, Application For Missouri Military Personalized License Plates, respectively. The Application For Missouri Personalized And Special License Plates, revised October 2008 and Application For Missouri Military Personalized License Plates, revised July 2008, both of which are incorporated by reference, are published by and can be obtained from the Missouri Department of Revenue, PO Box 43, Jefferson City, MO 65105-0043 or at <http://dor.mo.gov/mvdl/motorv/forms/>. These applications do not include any amendments or additions to their October 2008 and July 2008 editions respectively. Initial applications must be submitted to the Department of Revenue, PO Box 569, Jefferson City, MO 65105-0569] appropriate forms and accompanied by any special license plate fee and additional documentation as required by law. [Applications shall be accompanied by a special license plate fee of fifteen dollars (\$15), and a current emblem-use authorization statement or proof of military service, if required by law.]*

[(11) Reapplications (renewals) for special license plates shall be filed with the Department of Revenue prior to the last day of the month in which they expire.]

[(12)](11) The director of revenue may recall any special license plate erroneously issued under this rule.

AUTHORITY: sections 301.144 [and 301.451], *[RSMo Supp. 2008 and section] 301.449, and 301.453, RSMo [2000] 2016, and section 301.130, RSMo Supp. 2018. Original rule filed Aug. 14, 1978, effective Nov. 13, 1978. For intervening history, please consult the Code of State Regulations. Amended: Filed Oct. 25, 2018.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Revenue, General Counsel's Office, PO Box 475, Jefferson City, MO 65105-0475. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.

**Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 23—Motor Vehicle**

PROPOSED AMENDMENT

12 CSR 10-23.260 Inspection of *[Foreign Motor]* Non-USA Standard Vehicles Prior to Titling. The department is amending the title, revising section (2), and removing the image of form 551 herein.

PURPOSE: This rule is being amended to remove the image of form 551.

(2) Some motor vehicles which are purchased by Missouri residents in another country and imported into the United States are manufactured for importation into the United States and conform to all legal standards. The ownership document for these vehicles is usually a Manufacturer's Statement of Origin similar to the type issued for a motor vehicle constructed by an American manufacturer.

(A) Any application for title to a motor vehicle imported into the United States which is accompanied by a Manufacturer's Statement of Origin need not be accompanied by a DOR Form 551/[B)]. If problems are encountered at the time the application is entered into the Department of Revenue's computer, the central office will inform the applicant to contact the Missouri State Highway Patrol to request that they inspect the vehicle and complete a Vehicle Examination Certificate.

AUTHORITY: section 301.190, *RSMo [1986] 2016. Original rule filed March 21, 1986, effective July 11, 1986. Amended: Filed Oct. 25, 2018.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Revenue, General Counsel's Office, PO Box 475, Jefferson City, MO 65105-0475. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 23—Motor Vehicle

PROPOSED AMENDMENT

12 CSR 10-23.280 Replacement of Multiyear License Plates. The department is amending sections (1) and (2).

PURPOSE: This amendment is to update the life span reference to license plates and remove language mandating the applicant keep the same configuration.

(1) In January 1979 the Department of Revenue began issuing multiyear license plates. The categories of multiyear license plates are: passenger; recreational vehicle; motorcycle; motortricycle; commercial motor vehicles licensed as Local (L) 6000 and 12,000, Beyond Local (BL) 9000, BL 6000, and 12,000; shuttle bus; and van pool. These license plates were subjected to manufacturing processes, which guarantee a minimum useful life of *[five (5)] six (6)* years. Holders of multiyear license plates issued at least *[five (5)] six (6)* years previously may be issued new license plates upon the payment of the annual registration (renewal) fee subject to the procedures outlined that follow:

(C) If the owner of multiyear license plates requests new license plates upon renewal, but declares that s/he cannot surrender his/her old license plates because they were lost, stolen, or destroyed, the applicant must complete an application for replacement plates and pay the appropriate replacement plate *[charge]* fee in addition to the regular registration fee. The applicant **may be issued new license plates from the office's current inventory stock. Upon request, applicant** will be issued validation tabs from the current inventory stock and a replacement permit and receipt. The replacement plates will be manufactured with the same configuration as the original plates and will be mailed to the applicant. The applicant will affix the new validation tabs to the replacement plates when they are received by him/her;

(D) If the owner of multiyear license plates requests new plates at any time other than during the month of renewal because the license plates currently on the vehicle are at least *[five (5)] six (6)* years old, s/he may be issued replacement plates at no fee; *however, the applicant must* **upon surrender of the damaged license plates. The applicant may be issued new license plates from the office's current inventory stock. Upon request, owner** will be issued replacement tabs and a replacement permit and receipt. The replacement plates will be manufactured with the same configuration as the original plates and mailed to the applicant;

(E) If the owner of multiyear license plates, which are at least *[five (5)] six (6)* years old, purchases another vehicle and does not wish to transfer the license plates, the applicant may pay the appropriate transfer fee, surrender the old plates and be issued replacement plates at no fee. The applicant will be issued replacement tabs, a replacement permit and receipt. The replacement plates will be manufactured with the same configuration as the original plates and mailed to the applicant;

(F) If the owner of multiyear license plates, which are at least *[five (5)] six (6)* years old, purchases another vehicle but does not wish to transfer the old license plates and refuses to surrender them, s/he may be issued a new set of license plates from the *[branch or fee agent]* office's current inventory stock. *S/he will be required to/ upon payment of* the appropriate registration fee and the failure to transfer fee; and

(G) If the owner of multiyear license plates, which are at least *[five (5)] six (6)* years old, has only one (1) license plate to surrender and declares the other license plate was lost, stolen, or destroyed, s/he may be issued a new set of multiyear license plates under the procedures established in subsection (1)(A) of this rule. The applicant will not be required to pay the failure to renew fee or apply for

one (1) replacement plate.

(2) An owner of multiyear license plates, which are less than *[five (5)] six (6)* years old, who either refuses to renew or to transfer the plates will be issued new plates, be charged the appropriate renewal fee, and be charged either a failure to renew or failure to transfer fee, whichever is applicable.

AUTHORITY: section 301.130, RSMo [1986] Supp. 2018. Original rule filed April 21, 1986, effective Aug. 11, 1986. Amended: Filed Oct. 25, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Revenue, General Counsel's Office, PO Box 475, Jefferson City, MO 65105-0475. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 23—Motor Vehicle

PROPOSED AMENDMENT

12 CSR 10-23.340 Imposition and Waiver of Motor Vehicle and Trailer Titling and Registration Penalties. The department is amending section (1) and the authority section.

PURPOSE: This rule is being amended to update and correct language and conform to the twenty-four thousand pound (24,000 lb.) special license plate rule amendment at 12 CSR 10-23.100.

(1) The department *[shall]* assesses penalties on three (3) types of motor vehicle and trailer titling and registration transactions. These penalties are—a delinquent registration renewal penalty, a failure to title penalty, and a failure to renew or transfer a multiyear license plate penalty. All penalties may be waived by the department under certain circumstances.

(A) Delinquent Registration Renewal Penalty. If an owner of a multiyear license plate submits his/her application for renewal on the first day of the month following the month of expiration of the license plate, a delinquent registration renewal penalty *[shall]* **will** be assessed. If the last day of the month of expiration falls on a Saturday, Sunday, or legal state holiday, the following state working day is penalty free. If, for example, an owner has November license plates and the last day of November falls on Sunday, **then** Monday, December 1 would be considered penalty free for all November renewals.

1. Once a motor vehicle is registered for use on Missouri highways, it is subject to *[annual]* registration **renewal**. The motor vehicle **registration** is to be *[registered annually]* **renewed** whether or not it is actually on or off the highways for any period of time. This obligation to *[register the vehicle annually]* **renew the registration** continues until the owner ceases to operate the vehicle on Missouri highways, at which time s/he is required to return his/her license plates to the director of revenue within ninety (90) days. If an owner of a motor vehicle surrenders his/her license plates to an office of the Department of Revenue within the ninety- (90-)/- day period after ceasing to operate the motor vehicle, s/he may register

that same vehicle again at a later date [(see subparagraphs (1)(A)1.A.–C.)] without being subject to a delinquent registration renewal penalty.

A. If an owner elects to renew the registration of a vehicle which s/he has ceased operating anytime during the twelve- (12-)/- month period following the expiration of the license plates, s/he will be issued the appropriate license plate and validation tabs and be charged the appropriate twelve- (12-)/- month registration fee. A delinquent registration renewal penalty [shall] will not be charged provided the owner submits the receipt documenting his/her surrender of previously issued license plates.

B. An owner's registration [shall] will be automatically cancelled after one (1) year from the date of expiration of a Missouri license plate. If an owner elects to cease operation of his/her vehicle, and the license plates on the vehicle have been expired for at least one (1) year, the owner will not be required to pay a delinquent registration renewal penalty if s/he elects to relicense the vehicle after one (1) year from the date of expiration of the license plates.

(B) Failure to Title Penalty. If a purchaser of a motor vehicle or trailer fails to make application for a certificate of ownership within thirty (30) days after acquiring a motor vehicle or trailer, the department [shall] assesses the title penalty set by law for each thirty (30)-day period of delinquency, not to exceed the maximum penalty allowed. The first penalty fee shall be assessed on the 31st day of delinquency. If the 30th, 60th, 90th, 120th, 150th, 180th, 210th, 240th or the 270th day of delinquency falls on a Saturday, Sunday, or legal state holiday, the penalty fee [shall] will not be imposed on the next state working day. If, for example, an individual purchases a motor vehicle on August 1, and the 30th day of the first period of delinquency falls on Sunday, August 31, the first penalty would not be imposed on Monday, September 1 but on Tuesday, September 2.

(C) Penalty for Failure to Renew or Transfer a Multiyear License Plate. A penalty fee [shall] will be imposed on any applicant who elects not to renew or transfer a multiyear license plate. Multiyear license plates are issued to— passenger vehicles; recreational vehicles; motorcycles; motortricycles; commercial motor vehicles registered for Local (L) [6,000, L 12,000,] and Beyond Local (BL) 6,000[, BL 9000 and BL 12,000] to 24,000; shuttle buses; and van pool vehicles. If an applicant does not renew the multiyear license plates currently registered to his/her vehicle, but requests that new multiyear license plates be issued, a penalty fee [shall] will not be imposed provided the applicant changes license plate categories. For example, if the applicant has regular passenger license plates and requests disabled person license plates, no failure to renew or transfer penalty [shall] will be imposed.

AUTHORITY: section[s] 301.050, RSMo 1986 301.190 and 301.300] 301.130, RSMo Supp. [1990] 2018. Original rule filed July 30, 1986, effective Nov. 28, 1986. Amended: Filed Oct. 25, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Revenue, General Counsel's Office, PO Box 475, Jefferson City, MO 65105-0475. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

Title 12—DEPARTMENT OF REVENUE

Division 10—Director of Revenue

Chapter 23—Motor Vehicle

PROPOSED AMENDMENT

12 CSR 10-23.345 Definition of Major Component Parts of a Motor Vehicle. The department is amending section (1), adding section (2), and removing the image herein.

PURPOSE: This rule is being amended to update language, add major component part(s) for motorcycles, and remove the associated image therein.

(1) The seven (7) major component parts which are commonly used to reconstruct a motor vehicle [shall be] are defined solely for reconstruction purposes as follows. The written definition of each major component part is further clarified by an artist's drawing]:

(E) Cowl—The sheet metal formed by severing the vehicle across the floor in the vicinity of the front seat and severing the windshield posts. It does not include parts forward of the firewall. If a cowl is included as an integrated part of a front clip, front-end assembly, or rear clip, it [shall] will not be considered a major component part for the purpose of determining the total number of the major component parts used in the reconstruction of a motor vehicle;

(2) The major component parts which are commonly used to reconstruct a motorcycle are defined solely for reconstruction purposes as follows:

- (A) Frame; and
- (B) Transmission.

AUTHORITY: section 301.010, RSMo Supp. [1989] 2018. Original rule filed Sept. 1, 1986, effective Nov. 28, 1986. Amended: Filed Oct. 25, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Revenue, General Counsel's Office, PO Box 475, Jefferson City, MO 65105-0475. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

Title 12—DEPARTMENT OF REVENUE

Division 10—Director of Revenue

Chapter 23—Motor Vehicle

PROPOSED AMENDMENT

12 CSR 10-23.350 Honorary Consular License Plates. The department is amending sections (1)–(7) and (9)–(13) and removing sections (14)–(16).

PURPOSE: This rule is being amended to update language and remove outdated information.

(1) Under the authority of the Foreign Missions Act, 22 U.S.C. Section 4301, the Office of Foreign Missions of the United States

Department of State *[has begun]* issu~~ing~~*les* a *[new]* series of motor vehicle license plates for vehicles owned by foreign missions and their authorized representatives. These *[new]* federal license plates replace and supersede the special diplomatic and consular plates formerly issued by the various states including Missouri. The *[new]* law also provides for federal titling of vehicles owned by foreign missions and their authorized representatives.

(2) The *[new]* federal license plates are issued to the following categories of personnel:

(3) The *[new]* federal license plates are easily recognizable, being painted red, white, and blue, are the standard six inches by twelve inches (6" × 12") in size, and bear the words Issued by the United States Department of State at the bottom.

(4) In accordance with the Foreign Missions Act, 22 U.S.C. Section 4301, the United States Department of State has directed that license plates issued by any state, including Missouri, to honorary consuls must contain words, symbols, and colors that are clearly distinguishable from the federal plates. Furthermore, each state has been requested to refrain from embossing the words, CONSULAR OFFICER on the license plates *[issued by the states]*. This procedure should assist law enforcement agencies in determining if the license plate displayed on a motor vehicle is a federal- or state-issued license plate. Missouri may not issue license plates to any motor vehicle which is required to be registered with the federal government.

(5) Honorary consuls are defined as United States nationals or permanent residents who are appointed as honorary consular officers of foreign missions. The United States Department of State has notified Missouri that honorary consuls will not be permitted to register their vehicles under the federal program. However, honorary consuls are authorized under section 26.140, RSMo to use Missouri motor vehicle license plates which identify them as honorary consular officers. Accordingly, the director of revenue has established a category of specialized personalized license plates for issuance to honorary consuls patterned after the provisions of section 301.144[.2.], RSMo.

(6) Honorary consular license plates *[shall]* consist of white letters and numerals on a royal blue field. The configuration of these plates *[shall]* consist of the letter C followed by a dash and the numerals one through and including sixty-six (1-66). At the bottom of the royal blue field *[shall]* appear the words HON. CONSUL in the place of Show Me State.

(7) No more than one (1) set of two (2) honorary consular license plates *[shall]* **will** be issued to a qualified applicant.

(9) Honorary consular license plates *[shall]* **will** only be issued to passenger motor vehicles subject to the registration fees provided in section 301.055, RSMo.

(10) Applicants for honorary consular license plates *[shall be]* **are** required to comply with all Missouri laws and rules relating to the taxing, titling, registration, and safety inspection of motor vehicles.

(11) Any person desiring to obtain a set of two (2) honorary consular license plates *[must]* **will** make application and *[shall]* pay a *[n annual]* personalized plate fee of fifteen dollars (\$15) in addition to the regular registration fees for passenger vehicles as detailed in section 301.055, RSMo. Initial application for honorary consular license plates *[shall be]* **are** submitted to the Department of Revenue, Motor Vehicle Bureau, P.O. Box 100, Jefferson City, MO 65105 and *[shall]* be accompanied by the personalized plate fee, *[a paid personal property tax receipt of the previous calendar year or a statement of nonassessment for the same period, a vehicle safety/emissions inspection not more than sixty (60) days old, a statement certifying proof of insurance]* **any**

other documents required by law to obtain registration, and a copy of the honorary consular officer identification card issued by the Missouri secretary of state. Upon approval, honorary consular license plates will be issued *[by the Motor Vehicle Bureau]*. Subsequent annual renewals may be accomplished at any *[branch or fee agent]* license office statewide where the renewing applicant will be issued universal registration renewal tabs.

(12) Prior to the receipt of honorary consular license plates, the applicant *[must]* **is to** surrender all previously issued license plates which bear the words Consular Officer and pay any additional fees due. If no consular officer plates were issued, the applicant *[must]* **is to** surrender the regular license plates which the honorary consular license plates will replace. If the honorary consular license plates are to be issued for a period of less than one (1) full year, the department *[shall]* **will** assess registration fees on a prorated basis. No refunds *[shall]* **are to** be made for any unused portion of registration fees for any license plates surrendered in exchange for honorary consular license plates.

(13) Applications for renewal of honorary consular license plates *[shall]* **will** be filed with the Department of Revenue prior to the last regular work day of January each year. All plates annually expire on January 31.

[(14) According to the United States Department of State, honorary consular officers who have been issued license plates identifying them as honorary consuls are not entitled to diplomatic immunity from any state, county or municipal parking or traffic laws or from arrest or detention for violation of those laws.]

[(15) According to the United States Department of State, honorary consuls are not exempt from any taxes whatsoever, including county or City of St. Louis personal property tax, state sales or use taxes, or local sales taxes. No tax exemption shall be granted in connection with any application for honorary consular license plates unless exempt status is certified to the department by the United States Department of State for each proposed transaction.]

[(16) On January 1, 1987, all consular officer license plates previously issued by the Missouri Department of Revenue which bear the words Consular Officer and which have white lettering on a red field shall become invalid.]

AUTHORITY: sections 26.140 [and], 301.135, [RSMo 1986] and 301.144, RSMo [Supp. 1989] **2016**. Original rule filed Oct. 3, 1986, effective Dec. 26, 1986. Emergency amendment filed Oct. 30, 1989, effective Nov. 9, 1989, expired March 8, 1990. Amended: Filed Oct. 30, 1989, effective Feb. 25, 1990. Amended: Filed Oct. 25, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Revenue, General Counsel's Office, PO Box 475, Jefferson City, MO 65105-0475. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.

**Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 23—Motor Vehicle**

PROPOSED AMENDMENT

12 CSR 10-23.370 Issuance of Certificates of Title to Recreational Vehicles Manufactured by Two Separate Manufacturers. The department is amending sections (1)–(2).

PURPOSE: This rule is being amended to update information and language and replace a definition of “motor home” with a definition of “recreational motor vehicle.”

(1) When recreational vehicles or *[motor homes]* **recreational motor vehicle** are manufactured by separate manufacturers and have separate and distinct Manufacturers’ Statements of Origin (MSO) issued for the unit, the following titling procedures *[shall]* apply:

(2) For the purpose of this rule, *[motor home]* **a recreational motor vehicle** shall be defined as *[a new vehicular unit, designed to provide temporary living quarters, built into as an integral part of, or permanently attached to a self-propelled motor vehicle chassis or van]* **any motor vehicle designed, constructed, or substantially modified so that it may be used and is used for the purposes of temporary housing quarters, including therein sleeping and eating facilities which are either permanently attached to the motor vehicle or attached to a unit which is securely attached to the motor vehicle.** The vehicle must contain permanently installed independent life support systems which meet the American National Standards Institute/National Fire Protection Association (ANSI/NFPA) 501C Standard and provide at least four (4) of the following facilities: cooking, refrigeration or ice box, self-contained toilet, heating or air conditioning, or both, a portable water supply system including a faucet and sink, separate one hundred ten to one hundred twenty-five (110–125)-volt electrical power supply or a liquefied petroleum (LP) gas supply or both. The basic types are specified as follows:

AUTHORITY: sections [301.010,] 301.190 and 301.200, RSMo [2000] 2016, and section 301.010, RSMo Supp. 2018. Original rule filed Dec. 2, 1986, effective March 12, 1987. Amended: Filed June 24, 2003, effective Dec. 30, 2003. Amended: Filed Oct. 25, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Revenue, General Counsel’s Office, PO Box 475, Jefferson City, MO 65105-0475. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 23—Motor Vehicle**

PROPOSED AMENDMENT

12 CSR 10-23.405 Emblem-Use Authorization Statement and

Format for Collegiate License Plates. The department is amending sections (1)–(3), deleting subsections (2)(A) and (B) and section (4), and amending and renumbering as necessary.

PURPOSE: This rule amendment is to update out of date references and fix consistency issues.

(1) Any community college or four- (4)-[] year public or private institution of higher education, **or a foundation or organization representing the college or institution**, located in Missouri authorizing the use of its official emblem to be affixed to a license plate annually *[must]* **will** issue an emblem-use authorization statement. The statement *[must]* **will be [on a form prescribed] in a format agreed upon** by the director of the Department of Revenue and *[must]* **which** includes the name of the community college or four- (4)-[] year public or private institution, the applicant’s name and address, the amount of *[fee]* **contribution** paid, and the date of payment.

(2) One (1) emblem-use authorization statement *[must]* **needs to be** issued for each collegiate license plate application. *[A statement issued prior to July 1 of any calendar year shall be accepted for applications for collegiate license plates with an expiration month of the upcoming October, with the exception of collegiate license plates issued during the first year of issuance (1990). In this case, statements dated prior to July 1, 1991 will be accepted for applications for collegiate license plates with an expiration in October, 1991. Statements issued after the last day of June of any calendar year will be accepted for applications for collegiate license plates to be issued or renewed in the coming October with an expiration month of the next succeeding October.]*

[(A) Example One: Emblem-use authorization statements dated before July 1, 1991 will result in issuance or renewal of collegiate license plates which expire in October 1991.

(B) Example Two: Emblem-use authorization statements dated after July 1, 1991 and before June 30, 1992 will result in issuance or renewal of collegiate license plates which expire in October 1992.]

(3) Any community college or four- (4)-[] year public or private institution of higher education which desires to have license plates issued which display its emblem, logo, or seal must *[issue four hundred fifty (450) emblem-use authorization statements]* **submit two-hundred (200) applications** before the Department of Revenue will authorize the manufacture of license plates displaying its emblem, logo, or seal.

[(4) Should the community college or four (4)- year public or private institution of higher education be unable to issue four hundred fifty (450) emblem-use authorization statements, the institution must establish a mechanism for refunding the contributions to the applicant for these statements in the event refunds are requested by the applicant. Refunds shall only be made in the event the minimum number of emblem-use authorization statements are not issued.]

[(5)](4) Any community college or four- (4)-[] year public or private institution of higher education *[which]* **desir[es]ing** to have collegiate license plates issued *[must]* **should** submit a preliminary design of the emblem, logo, or seal which it desires to be displayed upon the license plates as well as school colors that need to be included. This design *[must]* **will** be formatted in accordance with the design of the plate as prescribed in section *[(6)] (5)* of this rule. The department will submit the design to the vendor for the material to manufacture the plates. The vendor will prepare the finished artwork for the emblem, logo or seal and submit it to the Department of Revenue and the appropriate institution for approval. Upon approval, the department will authorize the manufacture of the

plates[, *provided the community college or four (4)-year public or private institution of higher education has issued the required minimum number of emblem-use authorization statements and has notified the Department of Revenue in writing that the required minimum number of emblem-use authorization statements have been issued to applicants*].

[(6)](5) [On the top of the collegiate license plate shall appear the words OCT and MO.] The left-hand portion of the plate will bear a reproduction of the college emblem, seal, or logo in an area not to exceed two and one-half inches by three inches (2 1/2" × 3"). Immediately to the right of the emblem, seal, or logo, [shall] will appear one to five (1-5) characters. The bottom of the license plate [shall] will bear the name of the community college or public or private institution of higher education, in lieu of SHOW ME STATE, in an area not to exceed eleven inches by one inch (11" × 1").

AUTHORITY: section 301.449, RSMo [Supp. 1990] 2016. Original rule filed Nov. 1, 1989, effective Feb. 25, 1990. Amended: Filed Oct. 25, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Revenue, General Counsel's Office, PO Box 475, Jefferson City, MO 65105-0475. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

Title 12—DEPARTMENT OF REVENUE

Division 10—Director of Revenue

Chapter 23—Motor Vehicle

PROPOSED AMENDMENT

12 CSR 10-23.424 Leasing Company Registration. The department is amending sections (3), (5), and (6).

PURPOSE: This amendment provides for issuing leasing company registrations on a staggered basis to equalize the Department of Revenue's workload.

(3) [Renewal applications for registration as a leasing company shall be filed with the director prior to December 1 of each registration period. Leasing company registrations shall expire on December 31 of each registration period.] The director may stagger expiration dates to equalize workload. Leasing companies with expired registrations [shall] will not be entitled to the sales tax option provided by section 144.070, RSMo, [but shall] and will pay all state and local sales tax on the purchase price of any units acquired while the registration is expired.

(5) Any transfer of a motor vehicle, trailer, boat, or outboard motor to another division from one (1) division of a corporation which authorizes a division to register as a motor vehicle leasing company [shall be] is a sale at retail as defined in section 144.010, RSMo.

(6) The director [shall] will deny application for, or recall any permit to operate as a leasing company, if the applicant—

(A) Has fraudulently completed the application for registration;

(B) No longer holds a valid Missouri sales tax license; or
(C) Is no longer properly registered with the Office of the Missouri Secretary of State.

AUTHORITY: sections 144.010, [RSMo Supp. 2003 and] 144.070, and 144.270, RSMo [2000] 2016. Emergency rule filed Oct. 28, 1991, effective Nov. 7, 1991, expired March 6, 1992. Emergency rule filed Feb. 26, 1992, effective March 7, 1992, expired July 5, 1992. Original rule filed Oct. 28, 1991, effective May 14, 1992. Amended: Filed Oct. 10, 2003, effective April 30, 2004. Amended: Filed Oct. 25, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Revenue, General Counsel's Office, PO Box 475, Jefferson City, MO 65105-0475. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

Title 12—DEPARTMENT OF REVENUE

Division 10—Director of Revenue

Chapter 26—Dealer Licensure

PROPOSED AMENDMENT

12 CSR 10-26.080 Procedural Requirements For Public Motor Vehicle Auctions. The department is amending sections (4)–(13), deleting section (3), and renumbering as needed.

PURPOSE: This rule amendment is to remove unnecessary information and update an outdated internet reference.

[(3) Each auction shall provide access to all records requested by Department of Revenue employees or law enforcement during normal business hours.]

[(4)](3) [Motor vehicles shall only be sold at an auction conducted by a licensed auctioneer.] The motor vehicle auction must be scheduled and publicized at least one (1) week prior to the sale date.

[(5)](4) Any individual conducting a public motor vehicle auction must be licensed pursuant to all applicable laws and make available for inspection all applicable licenses to law officers or Department of Revenue employees. An auction shall maintain a record of each individual performing auctioneering services and the inclusive dates of such services.

[(6)](5) Prior to selling any motor vehicle at auction, an auction shall review all applicable vehicle documentation, including but not limited to, the following: certificate of title and odometer disclosure statement, if applicable.

(A) Prior to selling a vehicle at auction, the auctioneer must announce any brands printed on the title, the condition of the vehicle, any known damage to the vehicle, the odometer reading of the vehicle, and any other information on the odometer disclosure statement.

[(7)](6) [Motor vehicles sold at auction are not required to be safety inspected.] Auctioneers shall announce at the beginning of each public auction that the vehicles offered for sale may not have

been safety inspected. *[Relevant signs shall be posted as required by statute.]*

[(8)](7) Both licensed dealers and the public may attend and buy or sell at a public motor vehicle auction.

[(9)](8) Motor vehicle auctions shall not accept for sale from a dealer any vehicle without a Federal Buyer's Guide affixed to the vehicle or which does not comply with other applicable state or federal disclosure requirements.

[(10)](9) An auction must verify that each dealer who sells at the auction is currently licensed as a motor vehicle dealer in the state of Missouri or another jurisdiction.

[(11)](10) A certificate of number (license) issued to an auction by the director must be prominently displayed at the auction's bona fide established place of business. A separate license must be obtained by each public motor vehicle auction.

[(12)](11) An auction may only conduct business at its licensed location. Off-site sales are prohibited.

[(13)](12) An auction must issue to the buyer and seller of each vehicle a document that contains—

- (A) The year, make, model, and vehicle identification number of the motor vehicle;
- (B) The name and address of the seller;
- (C) The name and address of the buyer;
- (D) The date of sale and the purchase price; and
- (E) The odometer reading of the motor vehicle at the time of sale.

AUTHORITY: *sections 301.550[–301.573] to 301.580, RSMo [1994 and Supp. 1998] 2016 and RSMo Supp. 2018. Original rule filed Nov. 1, 1999, effective May 30, 2000. Amended: Filed Oct. 25, 2018.*

PUBLIC COST: *This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

PRIVATE COST: *This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

NOTICE TO SUBMIT COMMENTS: *Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Revenue, General Counsel's Office, PO Box 475, Jefferson City, MO 65105-0475. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

Title 12—DEPARTMENT OF REVENUE

Division 10—Director of Revenue

Chapter 26—Dealer Licensure

PROPOSED AMENDMENT

12 CSR 10-26.180 Temporary Permits Sold by a Registered Missouri Motor Vehicle Dealer. The department is amending section (4).

PURPOSE: *This rule amendment increases a three- (3-) year period to five (5) years, in which certain temporary permit records are to be maintained.*

(4) Upon each sale of a temporary permit, each dealer shall fully complete all information on the temporary permit in accordance with

Department of Revenue instructions *[and complete all appropriate records of issuance found within the booklet of permits]*. If the permit is issued pursuant to a courtesy delivery arrangement, the dealer issuing the permit must record the words courtesy delivery on the corresponding permit *[and on the permit record within the permit booklet]*. The information listed shall be true, accurate, and complete. Temporary permits that are spoiled shall be marked void and kept as a part of the dealership's records. *[The] Temporary permit records shall be maintained [in booklet form] for a period of at least [three (3)] five (5) years for inspection by law enforcement or Department of Revenue officials.*

AUTHORITY: *section[s 301.140 and] 307.380, RSMo [2000] 2016, and section 301.140, RSMo Supp. 2018. This rule previously filed as 12 CSR 10-23.190. Original rule filed Oct. 1, 1985, effective Dec. 26, 1985. For intervening history, please consult the Code of State Regulations. Amended: Filed Oct. 25, 2018.*

PUBLIC COST: *This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

PRIVATE COST: *This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

NOTICE TO SUBMIT COMMENTS: *Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Revenue, General Counsel's Office, PO Box 475, Jefferson City, MO 65105-0475. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

Title 12—DEPARTMENT OF REVENUE

Division 10—Director of Revenue

Chapter 26—Dealer Licensure

PROPOSED AMENDMENT

12 CSR 10-26.190 Dealers' Monthly Reports. The department is amending sections (1)–(2) and (4)–(5).

PURPOSE: *This rule amendment requires dealers filing electronic sales reports to continue filing electronically and to file reports in months when they have zero (0) sales. The amendment also removes unnecessary information.*

(1) Every motor vehicle and boat dealer must file a monthly sales report on a form prescribed by the director of revenue in accordance with section 301.280, RSMo. This report shall be completed in full and *[actually]* received by the Department of Revenue on or before the fifteenth day of the month following the month for which the sales are being reported. (Example: Sales occurring during the month of July must be filed on or before August 15.)

[(B) If any monthly sales report required to be filed on or before a prescribed date is delivered after that date by United States mail, postage prepaid and addressed to the Department of Revenue, the date of the United States postmark stamped on the envelope shall be deemed to be the date of filing. Official United States postmarks will suffice as proof of mailing. Reports may also be submitted by certified mail, registered mail or the dealer may obtain a validated certificate of mailing or receipt from the United States Post Office to establish date of mailing.]

(2) *[If no sales occur in any given month, a report must be submitted for that month indicating no sales.]* Every motor vehicle and boat dealer filing sales reports electronically in accordance with section 301.280, RSMo shall continue to file reports

electronically even when monthly sale amounts do not meet the minimum amounts required to file electronically.

(4) Every motor vehicle and boat dealer shall retain copies of the sales reports *[submitted to the Department of Revenue as part of the records to be maintained at the dealership location as provided in section 301.560.1, RSMo]* and shall hold them available for inspection by appropriate law enforcement officials, and officials of the Department of Revenue.

(5) Every motor vehicle dealer shall submit *[the original blue]* a copy of the secure power of attorney form *[(see 12 CSR 10-23.420)]* in which the dealer is listed as purchaser and a copy of the corresponding certificate of title with the dealer's monthly sales reports as provided in 12 CSR 10-23.420.

AUTHORITY: sections 32.057 and 301.280, RSMo [2000] 2016, and section 301.560[. 1], RSMo Supp. [2003] 2018. This rule previously filed as 12 CSR 10-23.050. Original rule filed April 14, 1980, effective Sept. 12, 1980. For intervening history, please consult the *Code of State Regulations*. Amended: Filed Oct. 25, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Revenue, General Counsel's Office, PO Box 475, Jefferson City, MO 65105-0475. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 41—General Tax Provisions

PROPOSED AMENDMENT

12 CSR 10-41.010 Annual Adjusted Rate of Interest. The Director of Revenue proposes to amend section (1) to reflect the interest to be charged on unpaid, delinquent taxes.

PURPOSE: This proposed amendment establishes the annual adjusted rate of interest to be implemented and applied on taxes remaining unpaid during calendar year 2019.

(1) Pursuant to section 32.065, RSMo, the Director of Revenue upon official notice of the average predominant prime rate quoted by commercial banks to large businesses, as determined and reported by the Board of Governor's of the Federal Reserve System in the Federal Reserve Statistical Release H.15(519) for the month of September of each year has set, by administrative order, the annual adjusted rate of interest to be paid on unpaid amounts of taxes during the succeeding calendar year as follows:

Calendar Year	Rate of Interest on Unpaid Amounts of Taxes
1995	12%
1996	9%
1997	8%
1998	9%
1999	8%

2000	8%
2001	10%
2002	6%
2003	5%
2004	4%
2005	5%
2006	7%
2007	8%
2008	8%
2009	5%
2010	3%
2011	3%
2012	3%
2013	3%
2014	3%
2015	3%
2016	3%
2017	4%
2018	4%
2019	5%

AUTHORITY: section 32.065, RSMo 2016. Emergency rule filed Oct. 13, 1982, effective Oct. 23, 1982, expired Feb. 19, 1983. Original rule filed Nov. 5, 1982, effective Feb. 11, 1983. For intervening history, please consult the *Code of State Regulations*. Emergency amendment filed Oct. 22, 2018, effective Jan. 1, 2019, expires June 29, 2019. Amended: Filed Oct. 22, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate. This proposed amendment will result in an increase in the interest rate charged on delinquent taxes.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate. Although the 2019 interest rate imposed on delinquent taxes is one percent (1%) higher than the rate imposed in 2018. The actual number of affected taxpayers is unknown. See detailed fiscal note for further explanation.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Revenue, General Counsel's Office, PO Box 475, Jefferson City, MO 65105-0475. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

FISCAL NOTE PUBLIC COST

I. RULE NUMBER

Rule Number and Name:	12 CSR 10-41.010 Annual Adjusted Rate of Interest
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Counties	<i>This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate. This proposed amendment will result in an increase in the interest rate charged on delinquent taxes.</i>
Cities	
Special Taxing Districts	

III. WORKSHEET

The proposed amendment adjusts the rate of interest for fiscal year 2020 to five percent (5%), an increase of one percent over the rate in 2018.

The future amount of past due taxes is unknown. Although the 2019 interest rate imposed on delinquent taxes is one percent higher than the rate imposed in 2018. This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

Interest on Delinquent Taxes Paid to Department of Revenue

	Current Rule 4.00%	Proposed Amendment 5.00%
Past due tax amount	\$100.00	\$100.00
Interest Amount (%)	x 4.00	x 5.00
Total Amount Due	\$104.00	\$105.00

IV. ASSUMPTIONS

Pursuant to Section 32.065, RSMo, the Director of Revenue is mandated to establish an annual adjusted rate of interest based upon the adjusted prime rate charged by banks during September of that year, as set by the Board of Governors of the Federal Reserve, rounded to the nearest full percentage. The actual bank prime loan rate noted by the Federal Reserve in 2018 was 5 percent.

FISCAL NOTE
PRIVATE COST

I. RULE NUMBER

Rule Number and Name:	12 CSR 10-41.010 Annual Adjusted Rate of Interest
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by adoption of the proposed rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
Any taxpayer with delinquent tax.	Any taxpayer with delinquent tax.	<i>This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate. Although the 2019 interest rate imposed on delinquent taxes is one percent higher than the rate imposed in 2018. The actual number of affected taxpayers is unknown. See detailed fiscal note for further explanation.</i>

III. WORKSHEET

The proposed amendment adjusts the rate of interest for fiscal year 2020 to five percent (5%), an increase of one percent over the rate in 2018.

This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate. Although the 2019 interest rate imposed on delinquent taxes is one percent higher than the rate imposed in 2018. The actual number of affected taxpayers is unknown.

Interest on Delinquent Taxes Paid to Department of Revenue

	Current Rule 4.00%	Proposed Amendment 5.00%
Past due tax amount	\$100.00	\$100.00
Interest Amount (%)	x 4.00	x 5.00
Total Amount Due	\$104.00	\$105.00

IV. ASSUMPTIONS

Pursuant to Section 32.065, RSMo, the Director of Revenue is mandated to establish an annual adjusted rate of interest based upon the adjusted prime rate charged by banks during September of that year, as set by the Board of Governors of the Federal Reserve, rounded to the nearest full percentage. The actual bank prime loan rate noted by the Federal Reserve in 2018 was 5 percent.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 35—Children's Division
Chapter 34—Homeless, Dependent and Neglected Children

PROPOSED AMENDMENT

13 CSR 35-34.080 Children's Income Disbursement System (KIDS). The division is amending sections (2), (3), (5), (6), (7), and (8).

PURPOSE: This amendment updates policy and practice regarding funds distributed into the Children's Income Disbursement System for youth in the custody of Children's Division.

(2) When a child is placed in the legal custody of the Children's Division (CD) under Chapter 211, RSMo, the CD shall establish an account to receive and hold *[any]* money received by the division on behalf of the child. *[All m/Monies received by a child in the custody of the CD shall be processed through the Children's Services Income Disbursement System (KIDS), also known as the Alternative Care Trust Fund].*

(B) The funds received *[must]* **may** be applied toward the care of the child prior to authorizing payment from state or federal funds for the child's care.

(C) These funds shall be received by the Division of *[Budget and Finance (DBF)] Finance and Administrative Services (DFAS)* for deposit with a financial institution and *[disbursement in the Alternative Care Trust Fund and]* accounted for in the name of the child **in the Children's Income Disbursement System (KIDS).**

(3) *[All m/Money received on behalf of the child shall be processed through [DBF] the Division of Finance and Administrative Services.*

(A) The director of the Children's Division shall **apply to be [designated as] the** payee for any independent source of benefits for children in the care and custody of CD.

(B) Once the child's KIDS account has been established, the payer shall be instructed to send the income directly to *[DBF] DFAS* who will enter the funds into the KIDS account.

(C) Any **Social Security or Veteran's Administration (VA)** monies received by the county office for deposit in a child's KIDS account must be registered on the appropriate form and sent to *[DBF] DFAS* for deposit into the KIDS account. **Any child support money received in the county office for deposit must be sent to the Child Support Financial Resolutions Section prior to deposit.**

[(D) Each Children's Division circuit manager shall designate a three (3) person monitoring team of three (3) CD employees within the circuit to monitor the KIDS accounts for children within that circuit to assure program integrity.]

(5) The division may accept funds which a parent, guardian, or other person voluntarily wishes to provide for the use and benefit of the child. The use and deposit of such funds shall be governed by 210.560, RSMo and any additional directions given by the provider of the funds.

(A) *[Any m/Monies received voluntarily from any parent, guardian, or other person on behalf of a child for deposit in the child's [KIDS] account shall be disbursed as provided in section (4) of this rule unless the person providing the funds furnishes specific, clear written instructions at the time that the funds are provided directing how the funds shall be used. The division shall keep the instructions with the child's records as provided in section (6) below. If the division is unable to disburse the funds in the manner provided in the written instructions, or if the written instructions are unclear, the division shall provide written notice to the person provides the funds and request further written instructions regarding disbursement of the funds. If the division does not receive written instructions*

within thirty (30) days of the date that the notice is given, the division may, at the division's discretion, disburse the funds as provided in section (4) of this rule or refund the balance of monies provided to the person providing the funds.

(6) A copy of all forms, statements, and information on each child's *[KIDS]* account shall be maintained with child's records for *[six (6)] five (5)* years after the child's case is closed.

(7) When a child leaves alternative care, the CD shall contact *[the Family Support Division (FSD), Financial Management and Operational Services Section (FM and OS)] the **FACES Payment Unit***, for the determination of prior expenses which should be paid from the KIDS account. *[FSD (FM and OS)] The **FACES Payment Unit*** shall determine prior expenses for five (5) years prior to the date the child left alternative care pursuant to section 516.120, RSMo. *[FSD (FM and OS)] The **FACES Payment Unit*** will process prior expenses to be paid from the KIDS account through fund recoupments for payments made on behalf of the child.

(8) The division shall furnish an annual, itemized statement *[to the child and the child's guardian ad litem]* listing all transactions involving the funds which have been deposited or disbursed on the child's behalf from the **child's account to the child's guardian ad litem**. The statements and supporting documentation shall be open to inspection to the guardian *[ad litem] ad litem* and the child.

AUTHORITY: sections [210.560] 207.020 and 660.017, RSMo [2000] 2016. Original rule filed Oct. 7, 2005, effective April 30, 2006. Amended: Filed Oct. 17, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Social Services, Legal Services Division-Rulemaking, PO Box 1527, Jefferson City, MO 65102-1527, or by email to Rules.Comment@dss.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 94—Rural Health Clinic Program

PROPOSED AMENDMENT

13 CSR 70-94.010 Independent Rural Health Clinic Program. The division is amending sections (4), (5), (7), and (8), removing sections (9), (10), and (12), and renumbering section (11).

PURPOSE: This rule is being amended to reflect the current cost report form and related worksheets, provide an exemption to the cost report filing requirements, and to clarify documentation and record retention requirements, interim payments, and final settlements.

(4) Definitions. The following definitions shall apply for the purpose of this rule:

(E) Medicaid cost report. The documents used~~/,~~ for the purpose of reporting the cost of rendering both covered and non-covered services for the facility's fiscal year~~/,~~ shall be the Medicare cost report forms *[(HCFA-222 (3/83))] CMS-222-92* and all worksheets supplied by

the division. **If the Medicare CMS-222-92 is superseded by an alternate Medicare developed cost reporting tool during a facility's fiscal year, that tool must be used for the facility's fiscal year;** and

(5) Administrative Actions.

(A) Annual Cost Report.

1. Each independent RHC shall complete a Medicaid cost report for the RHC's twelve- (12-)/- month fiscal period.

2. Each RHC is required to complete and submit to the division an Annual Cost Report, including all worksheets, attachments, schedules, and requests for additional information from the division. The cost report shall be submitted on forms provided by the division for that purpose.

A. An independent RHC may be exempt from filing a Medicaid cost report if there is no MO HealthNet reimbursement for the reporting period and the facility does not plan to bill the MO HealthNet program for any claims for the reporting period. The facility must submit a request to the division to waive the cost report filing requirement within five (5) calendar months after the close of the facility's reporting period. To request an exemption for the cost report filing requirement, the following information must be submitted to MHD for review and approval:

(I) A Low or No Missouri Medicaid Utilization Waiver Request Form. This form may be obtained from the division. The form must be fully completed and signed by an officer or administrator; and

(II) Worksheet S series of the Medicare Cost Report. The applicable parts of the Worksheet S must be completed and signed by an officer or administrator.

3. All cost reports shall be completed in accordance with the requirements of this rule and the cost report instructions. Financial reporting shall adhere to GAAP except as otherwise specifically indicated in this rule.

4. The cost report shall be submitted within five (5) calendar months after the close of the reporting period. *[A single/ An extension/, not to exceed thirty (30) days,]* may be granted upon the request of the RHC and the approval of the division **with an agreed upon date of completion.** The request must be received in writing by the division prior to the end of the five (5) calendar-month period after the close of the reporting period.

5. In a change of ownership, the cost report for the closing period must be submitted within forty-five (45) calendar days of the effective date of the change of ownership, unless the change in ownership coincides with the seller's fiscal year end, in which case the cost report must be submitted within five (5) months after the close of the reporting period. No extensions in the submitting of cost reports shall be granted when a change in ownership has occurred.

6. Cost reports shall be submitted and certified by an officer or administrator of the provider. Failure to file a cost report within the prescribed period, except as expressly extended in writing by the state agency, may result in the imposition of sanctions as described in 13 CSR 70-3.030.

7. Authenticated copies of agreements and other significant documents related to the provider's operation and provision of care to MO HealthNet participants must be attached to the cost report at the time of filing unless current and accurate copies have already been filed with the division. Material which must be submitted includes, but is not limited to, the following:

A. Audit, review, or compilation statement prepared by an independent accountant, including disclosure statements and management letter;

B. Contracts or agreements involving the purchase of facilities or equipment during the **past** five (5) years if requested by the division, the department, or its agents;

C. Contracts or agreements with owners or related parties;

D. Contracts with consultants;

E. Schedule detailing all grants, gifts, and income from endowments, including amounts, restrictions, and use;

F. Documentation of expenditures, by line item, made under all restricted and unrestricted grants, gifts, or endowments;

G. Statement verifying the restrictions as specified by the donor, prior to donation, for all restricted grants;

H. Leases or rental agreements, or both, related to the activities of the provider;

I. Management contracts;

J. Provider of service contracts; and

K. Working trial balance actually used to prepare cost report with line number tracing notations or similar identifications.

8. Under no circumstance will the division accept amended cost reports for final settlement determination or adjustment after the date of the division's notification of the final settlement amount.

(B) Records.

1. Maintenance and availability of records.

A. A provider must keep records in accordance with GAAP and maintain sufficient internal control and documentation to satisfy audit requirements and other requirements of this rule, including reasonable requests by the division or its authorized agent for additional information.

B. Adequate documentation for all line items on the cost report shall be maintained by a provider. Upon request, all original documentation and records must be made available for review by the division or its authorized agent at the same site at which the services were provided. Copies of documentation and records shall be submitted to the division or its authorized agent upon request.

C. Records of related organization, as defined by 42 CFR 413.17, must be available upon demand.

D. The division shall retain all uniform cost reports submitted by the independent RHCs *for [a period of at least three (3) years following the date of submission of the reports and will maintain those reports pursuant to the record-keeping requirements of 42 CFR 413.20] seven (7) years after the final settlement relating to a cost report is finalized, including the resolution of any subsequent appeals or other administrative actions pertaining to the cost report.*

E. Each facility shall retain all financial information, data, and records relating to the operation and reimbursement of the facility *for [a period of not less than five (5) years] seven (7) years after the final settlement relating to a cost report is finalized, including the resolution of any subsequent appeals or other administrative actions pertaining to the cost report, and will maintain those reports pursuant to the record-keeping requirements of 42 CFR 413.20.*

2. Adequacy of records.

A. The division may suspend reimbursement or reduce payments to the appropriate fee schedule amounts if it determines that the RHC does not maintain records that provide an adequate basis to determine payments under MO HealthNet.

B. The suspension or reduction continues until the RHC demonstrates to the division's satisfaction that it does, and will continue to, maintain adequate records.

(7) Interim Payments.

(B) An independent RHC *[in/ contracted with a MO HealthNet managed care [region/ health plan]* shall be eligible for supplemental reimbursement up to its interim Medicare RHC rate. *[This/ The supplemental reimbursement shall make up the difference between what the independent RHC would have been paid by the division based on the independent RHC's Medicare rate and the total managed care health plan payments made to the clinic during the reporting period for [managed care participants for/ covered services rendered to MO HealthNet managed care participants [during the reporting period] as set forth in the Managed Care contract.* The supplemental reimbursement shall occur pursuant to the schedule agreed to by the division and the independent RHC but shall occur no less frequently than every four (4) months. Supplemental reimbursement shall be requested **by the independent RHC** on forms provided by the division. Supplemental reimbursement for

managed care charges shall be considered interim reimbursement of the independent RHC's MO HealthNet costs.

(8) [Reconciliation] Final Settlement.

(A) **Final Settlement Determination.** The state agency shall perform an annual desk review of the Medicaid cost reports for each RHC's fiscal year and shall make *[indicated]* the necessary payment adjustments *[of]* (i.e., an additional payment or a recoupment), in order that the RHC's net reimbursement shall equal reasonable costs as described in this section.

1. The total reimbursement amount due the RHC for covered services furnished to MO HealthNet participants is based on the **allowable costs from the** Medicaid cost report and is calculated as follows:

A. The average cost per visit is calculated by dividing the total allowable cost incurred for the reporting period by total visits for RHC services furnished during this period. The average cost per visit is subject to tests of reasonableness which may be established in accordance with this rule or incorporated in the Allowable Cost per visit as determined on Worksheet *[3.A., line 7] C, Part I, line 9 of the cost report.*

B. The total cost of RHC services furnished to MO HealthNet participants is calculated by multiplying the allowable cost per visit by the number of MO HealthNet visits for covered RHC services.

2. The total reimbursable cost is compared *[with total payments and third party liability made to the RHC for the reporting period.]* to the total interim payments made to the RHC during the reporting period for MO HealthNet participants to determine the amount of the final settlement owed to or due from the RHC. The total interim payments include the amount paid by the division as determined from the division's MMIS reports, the health plan payments as set forth in the Managed Care contract, and third party liability payments.

3. The total reimbursement will be subject to adjustment based on the results of a field audit which may be conducted by the MO HealthNet Division or its contracted agents.

(B) [Notice of Program Reimbursement] Notification of Final Settlement.

1. The division will notify the RHC by letter of a cost report final settlement after the division completes the desk review of the cost report. The division's notification letter will include the calculation of the final settlement and a Settlement Agreement, which the facility will sign and return to the division indicating it agrees with the final settlement calculation. The division's *[shall send]* written notice to the RHC *[of]* shall indicate if the final settlement results in the following:

[1./A. Underpayments. If the total reimbursement due the RHC exceeds the interim payments made for the reporting period, the division makes a lump-sum payment to the RHC to bring total *[interim]* payments into agreement with total reimbursement due the RHC; and

[2./B. Overpayments. If the total interim payments made to a RHC for the reporting period exceed the total reimbursement due the RHC for the period, the division arranges with the RHC for repayment *[through a lump sum refund, or, if that poses a hardship for the RHC, through]* of the overpayment either by having it offset against the RHC's subsequent interim payments, having the RHC repay by sending the division a payment, or a combination of offset and *[refund]* payment.

2. The RHC shall review the division's notification letter and attachments and respond with a signed Settlement Agreement indicating it has accepted the final settlement within fifteen (15) calendar days of receiving the final settlement letter. If the RHC believes revisions to the division's desk review and final settlement are necessary before it can accept the settlement, it must submit additional, amended, or corrected data within the fifteen-(15-) day deadline. Data received from the RHC after the fifteen-(15-) day deadline may not be considered by the division in deter-

mining if revisions to the final settlement are needed unless the RHC requests and receives an extension for submitting additional information prior to the end of the fifteen- (15-) day deadline. If the fifteen- (15-) day deadline passes without a response from the provider, the division will proceed with processing the final settlement as set forth in the division's notification letter, and the final settlement shall be deemed final. The division may not accept an amended cost report or any other additional information to revise the cost report or final settlement after the final settlement is finalized.

[(9) Sanctions.

(A) *The division may impose sanctions against a provider in accordance with 13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for Title XIX Services or any other sanction authorized by state or federal law or regulation.*

(B) *Overpayments due the MO HealthNet program from a provider shall be recovered by the division in accordance with 13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for Title XIX Services.*

(10) Appeals. *In accordance with sections 208.156 and 621.055, RSMo, providers may seek hearing before the Administrative Hearing Commission of final decisions of the director, Department of Social Services or the MO HealthNet Division.]*

[(11)](9) Payment Assurance.

(A) The state will pay each RHC, which furnishes the services in accordance with the requirements of the state plan, the amount determined for services furnished by the RHC according to the standards and methods set forth in the regulations implementing the RHC Reimbursement Program.

(B) RHC services provided for those participants having available Medicare benefits shall be reimbursed by MO HealthNet to the extent of the coinsurance and deductible as imposed under Title XVIII.

(C) Where third-party payment is involved, MO HealthNet will be the payer of last resort.

(D) Regardless of changes of ownership, management, control, leasehold interests by whatever form for any RHC previously certified for participation in the MO HealthNet program, the division will continue to make all the Title XIX payments directly to the entity with the RHC's current provider number and hold the entity with the current provider number responsible for all MO HealthNet liabilities.

[(12) Payment in Full. *Participation in the MO HealthNet program shall be limited to providers who accept as payment in full, for covered services rendered to MO HealthNet participants, the amount paid in accordance with these rules and applicable copayments.]*

AUTHORITY: *sections 208.201 and 660.017, RSMo [Supp. 2007] 2016. Emergency rule filed Aug. 20, 1993, effective Sept. 18, 1993, expired Jan. 15, 1994. Emergency rule filed Jan. 19, 1994, effective Jan. 29, 1994, expired Jan. 31, 1994. Original rule filed Aug. 20, 1993, effective Jan. 31, 1994. Amended: Filed Aug. 15, 2008, effective Feb. 28, 2009. Amended: Filed Oct. 17, 2018.*

PUBLIC COST: *This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

PRIVATE COST: *This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

NOTICE TO SUBMIT COMMENTS: *Anyone may file a statement in support of or in opposition to this proposed amendment with the*

Department of Social Services, Legal Services Division-Rulemaking, PO Box 1527, Jefferson City, MO 65102-1527, or by email to Rules.Comment@dss.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 110—Division of Youth Services
Chapter 3—[Aftercare Responsibilities]
Case Management

PROPOSED AMENDMENT

13 CSR 110-3.030 Aftercare Supervision. The division is amending the chapter title and all sections.

PURPOSE: This amendment changes the chapter title and removes sections (2) and (3) as they are covered in other regulations and division policies. It amends section (4) to change the terminology of Foster Care to Alternative Care Givers in order to draw a distinction between it and the Children's Division's Foster Care Program. It also amends outdated terminology and removes repetitive language.

(1) Community Placement. *[It is the responsibility of the service coordinator to provide]* **The Division of Youth Services will ensure the appropriate treatment services are in place** for the *[client]* youth and his/her family.

[(2) Case Recordings. The service coordinator shall maintain the following records:

(A) A record of dates and type of contacts made on each youth; and

(B) A monthly summary will be prepared for each youth. The summary will include the date and times of contacts as well as client progress and future planning and

(C) It is mandatory that each six (6) months an evaluation be completed on all youth committed to the Division of Youth Services (DYS).

(3) Transfers. Transfer of an aftercare case shall be made as follows:

(A) To Interstate. (see 13 CSR 110-2.130(2));

(B) Transfers between regions must be approved by the two (2) regional administrators involved; and

(C) To Other Agencies. Transfers to other agencies will be coordinated through the special services administrator.]

[(4)](2) [Foster Care] Placement with Alternative Caregivers. Except in cases of emergency, children under Division of Youth Services supervision and placed in *[foster]* **alternative caregiver** homes funded by DYS shall be so placed only after an evaluation of the home has been completed. This evaluation shall include, but not be limited to, the adequacy of the home, family stability and composition, and the motivation and ability of the *[foster parents]* **alternative caregivers** to provide *[foster]* care. **An alternative caregiver may be a relative or a person who is not related to the youth but has a close relationship with the youth or the youth's family.**

(A) Preparation for Placement. [It is the responsibility of the service coordinator to] **The Division of Youth Services shall prepare the family and the youth for the impending placement.** That preparation may include, but not be limited to, the following:

1. Counseling and training with the *[foster family]* **alternative caregivers;**

2. Preplacement visits between the *[child]* youth and the *[foster family]* **alternative caregivers;**

3. Explanation of agency rates of payment and guidelines for expenditures of money *[in]* **on the [foster child's] youth's behalf;**

4. Evaluation of any other income the *[child]* youth might have, such as Social Security benefits, Veteran's Administration benefits, etc., as well as the youth's family's financial situation. The applicability of these funds to the *[child's]* youth's needs will be determined by the regional administrator; **and**

5. Discussion of arrangement for payment of special needs, such as, medical expenses, educational, or therapeutic, etc.; *and]*

[6. All foster homes will be approved prior to the child's placement by the regional administrator. All foster home placements will be approved by the regional administrator.

(B) Services to Family and Youth. The service coordinator will provide services to the youth and foster family as well as the youth's family.]

[(5)](3) Contractual Residential Services. [The need for the services will be determined by the regional administrator prior to the placement of a youth. The regional administrator will ensure that funds are available.] **The Division of Youth Services may utilize contractual residential services when it determines that the youth's needs are beyond the scope of services available at a Division of Youth Services' operated facility or space is not available at a Division of Youth Services' facility in close proximity to the youth's home or family.**

[(6)](4) Return to Facility (Shelter). A temporary return of the youth in aftercare to the *[institutional]* facility for reasonable cause may be permitted upon the recommendation of the service coordinator with the approval of the regional administrator. Reasonable cause is to be determined only upon the basis of need for alternative placement with none immediately available. *[Where]* **When** the youth is returned for shelter, every effort is to be made by the service coordinator to complete alternate placement plans within thirty (30) days. *[A report will be submitted each week that the youth is in shelter over thirty (30) days. The report will be submitted to the regional administrator justifying the continued need for shelter and outlining plans for alternative arrangements with a copy to the facility providing shelter.]* **Shelter placements may extend beyond 30 days with approval by the regional administrator.** When a placement is established by the service coordinator, *[s/he]* **the service coordinator** will notify the facility and make arrangements for the youth to be released with the approval of *[his/her]* **the service coordinator's** supervisor.

[(7)](5) Return to Facility ([Sanction] Revocation). Procedure for the return of youths held in violation of the conditions of aftercare supervision is outlined in 13 CSR 110-3.040 *[and 13 CSR 110-3.050].*

[(8)](6) Discharges from Aftercare Supervision. Section 219.026, RSMo *[1994]*, requires the division to immediately notify in writing the youth, his/her parent(s) or guardian(s), victim's rights respondent, and the committing court of the termination of its supervision over the youth.

AUTHORITY: sections 219.016, 219.036, and 660.017, RSMo *[1994]* 2016. Original rule filed Dec. 30, 1975, effective Jan. 9, 1976. Amended: Filed Feb. 10, 2000, effective Aug. 30, 2000. Amended: Filed Oct. 30, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the

Department of Social Services, Legal Services Division-Rulemaking, PO Box 1527, Jefferson City, MO 65102-1527, or by email to Rules.Comment@dss.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES

Division 30—Division of Regulation and Licensure Chapter 1—Controlled Substances

EMERGENCY AMENDMENT

19 CSR 30-1.002 Schedules of Controlled Substances. The department is amending section (1) Schedules of Controlled Substances.

PURPOSE: This emergency amendment updates the list of all drugs falling within the purview of controlled substances to match the corresponding list promulgated by the Drug Enforcement Administration (DEA).

(1) Schedules of Controlled Substances.

(A) Schedule I shall consist of the drugs and other substances[,] by whatever official name, common or usual name, chemical name or brand name designated[,] listed in this section. Each drug or substance has been assigned the Drug Enforcement Administration (DEA) Controlled Substances Code Number set forth opposite it.

1. Opiates. Unless specifically excepted or unless listed in another schedule, any of the following opiates, including their isomers, esters, ethers, salts, and salts of isomers, esters and ethers, whenever the existence of such isomers, esters, ethers, and salts is possible within the specific chemical designation:

A. Acetyl-alpha-methylfentanyl ((N)-1-(1-methyl-2-phenethyl)-4-piperidinyl)-/N-phenylacetamide)	9815
B. Acetylmethadol	9601
C. Acetyl fentanyl (N-(1-phenethylpiperidin-4-yl)-N-phenylacetamide)	9821
[C./D. AH-7921(3,4-dichloro-/N)-[(1-dimethylamino)cyclohexylmethyl] benzamide)	9551
[D./E. Allylprodine	9602
[E./F. Alphacetylmethadol (except levoalphacetylmethadol also known as levo-alpha-acetylmethadol levorhodyl acetate or LAAM)	9603
[F./G. Alphameprodine	9604
[G./H. Alphamethadol	9605
[H./I. Alpha-methylfentanyl ((N)-1-(alphamethyl-beta-phenyl) ethyl-4-piperidinyl) propionanilide; 1-(1-methyl-2-phenylethyl)-4 ((N)-propanilido) piperidine)	9814
[I./J. Alpha-methylthiofentanyl ((N)-1-methyl-2-(2-thienyl) ethyl-4-piperidinyl)-/N-phenylpropanamide)	9832
[J./K. Benzethidine	9606
[K./L. Betacetylmethadol	9607
[L./M. Beta-hydroxyfentanyl ((N)-1-(2-hydroxy-2-phenethyl)-4-piperidinyl)-/N-phenylpropanamide)	9830
[M./N. Beta-hydroxy-3-methylfentanyl (Other name: /N)-1-(2-hydroxy-2-phenethyl)-3-methyl-4-piperidinyl)-/N-phenylpropanamide//;	9831
[N./O. Betameprodine	9608
[O./P. Betamethadol	9609
[P./Q. Betaprodine	9611
[Q./R. Clonitazene	9612
[R./S. Dextromoramide	9613

[S./T. Diampromide	9615
[T./U. Diethylthiambutene	9616
[U./V. Difenoquin	9168
[V./W. Dimenoxadol	9617
[W./X. Dimephtanol	9618
[X./Y. Dimethylthiambutene	9619
[Y./Z. Dioxaphetyl butyrate	9621
[Z./AA. Dipipanone	9622
[AA./BB. Ethylmethylthiambutene	9623
[BB./CC. Etonitazene	9624
[CC./DD. Etozeridine	9625
[DD./EE. Furethidine	9626
[EE./FF. Hydroxypethidine	9627
[FF./GG. Ketobemidone	9628
[GG./HH. Levomoramide	9629
[HH./II. Levophenacilmorphan	9631
[II./JJ. 3-Methylfentanyl ((N)-1-(3-methyl-1-(2-phenylethyl)-4-piperidinyl)-/N-phenylpropanamide), its optical and geometric isomers, salts, and salts of isomers	9813
[JJ./KK. 3-Methylthiofentanyl ((N)-1-(3-methyl-1-(2-thienyl)ethyl-4-piperidinyl)-/N-phenylpropanamide)	9833
[KK./LL. Morpheridine	9632
[LL./MM. MPPP (1-methyl-4-phenyl-4-propionoxypiperidine)	9661
NN. MT-45 (1-cyclohexyl-4-(1,2-diphenylethyl)piperazine)	(9560)
[MM./OO. Noracymethadol	9633
[NN./PP. Norlevorphanol	9634
[OO./QQ. Normethadone	9635
[PP./RR. Norpipanone	9636
[QQ./SS. Para-fluorofentanyl((N)-N-(4-fluorophenyl)-/N)-1-(2-phenethyl)-4-piperidinyl//	9812
[RR./TT. PEPAP (1-(2-phenethyl)-4-phenyl-4-acetoxypiperidine)	9663
[SS./UU. Phenadoxone	9637
[TT./VV. Phenampromide	9638
[UU./WW. Phenomorphan	9647
[VV./XX. Phenoperidine	9641
[WW./YY. Piritramide	9642
[XX./ZZ. Proheptazine	9643
[YY./AAA. Properidine	9644
[ZZ./BBB. Propiram	9649
[AAA./CCC. Racemoramide	9645
[BBB./DDD. Thiofentanyl ((N)-N-phenyl-/N)-1-(2-thienyl)ethyl-4-piperidinyl)-propanamide	9835
[CCC./EEE. Tilidine	9750
[DDD./FFF. Trimeperidine	9646
2. Opium derivatives. Unless specifically excepted or unless listed in another schedule, any of the following opium derivatives, its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:	
A. Acetorphine	9319
B. Acetyldihydrocodeine	9051
C. Benzylmorphine	9052
D. Codeine methylbromide	9070
E. Codeine-/N)-Oxide	9053
F. Cyprenorphine	9054
G. Desomorphine	9055
H. Dihydromorphine	9145
I. Drotebanol	9335
J. Etorphine (except hydrochloride salt)	
9056	
K. Heroin	9200
L. Hydromorphanol	9301
M. Methylodesorphine	9302

N. Methyl dihydromorphine	9304	known as <i>/N/N</i> -ethyl alpha-methyl-3,4 (methylenedioxy) phenethylamine, <i>/N/N</i> -ethyl MDA, MDE, and MDEA)	7404
O. Morphine methylbromide	9305		
P. Morphine methylsulfonate	9306		
Q. Morphine-N-Oxide	9307	V. N-hydroxy-3,4-methylenedioxyamphetamine (also known as <i>/N/N</i> -hydroxy-alpha-methyl-3,4 (methylenedioxy) phenethylamine and <i>/N/N</i> -hydroxy MDA)	7402
R. Myrophine	9308	W. 3,4,5-trimethoxyamphetamine	7390
S. Nicocodeine	9309	X. 5-MeO-DMT or 5-methoxy- <i>/N/N</i> , <i>/N/N</i> -dimethyltryptamine	7431
T. Nicomorphine	9312	Y. Alpha-methyltryptamine	7432
U. Normorphine	9313	Z. Bufotenine	7433
V. Pholcodine	9314	Some trade and other names: 3-(b-Dimethylaminoethyl)-5-hydroxy-indole; 3-(2-dimethylaminoethyl)-5-indolol; <i>/N/N</i> , <i>/N/N</i> -dimethylserotonin; 5-hydroxy- <i>/N/N</i> , <i>/N/N</i> -dimethyltryptamine; map-pine;	
W. Thebacon	9315	AA. Diethyltryptamine	7434
3. Opiate similar synthetic substances. Substances scheduled by the United States Drug Enforcement Administration as substances that share a pharmacological profile similar to fentanyl, morphine, and other synthetic opioids, unless specifically excepted or unless listed in another schedule. These substances are:			
A. Butyryl fentanyl (<i>N</i> -(1-phenethylpiperidin-4-yl)- <i>N</i> -phenylbutyramide)	9822	Some trade and other names: <i>/N/N</i> , <i>/N/N</i> -Diethyltryptamine; DET;	
B. U-47700 (3,4-Dichloro- <i>N</i> -[2-(dimethylamino) cyclohexyl]- <i>N</i> -methyl benzamide)	9547	BB. Dimethyltryptamine	7435
[3.4. Hallucinogenic substances. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation, which contains any quantity of the following hallucinogenic substances or which contains any of its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation (For purposes of paragraph (1)(A)/3.4. of this rule only, the term isomer includes the optical, position, and geometric isomers.):			
A. Alpha-ethyltryptamine	7249	Some trade or other names: DMT;	
Some trade or other names: etryptamine; Monase; alpha-ethyl-1/ <i>H/H</i> -indole-3-ethenamine; 3-(2-aminobutyl)indole; alpha-ET; and AET;		CC. 5-methoxy- <i>/N/N</i> , <i>/N/N</i> -diisopropyltryptamine (other name: 5-MeO-DIPT)	7439
B. 4-bromo-2,5-dimethoxyamphetamine	7391	DD. Ibogaine	7260
Some trade or other names: 4-bromo-2, 5-dimethoxy-amethylphenethylamine; 4-bromo-2, 5-DMA;		Some trade and other names: 7-Ethyl-6,6β,7,8,9,10,12,13-octahydro-2-methoxy-6, 9-methano-5/ <i>H/H</i> -pyrido [1',2':1,2] azepino [5,4-b] indole; Tabernanthe iboga;	
C. 4-bromo-2,5-dimethoxyphenethylamine	7392	EE. Lysergic acid diethylamide	7315
D. 2,5-dimethoxyamphetamine	7396	FF. Marihuana	7360
Some trade or other names: 2,5-dimethoxy-amethylphenethylamine; 2,5-DMA;		Some trade or other names: marijuana;	
E. 2,5-dimethoxy-4-ethylamphetamine	7399	GG. Mescaline	7381
Some trade or other names: DOET;		HH. Paraheyl	7374
F. 2,5-dimethoxy-4-(n)-propylthiophenethylamine	7348	Some trade or other names: 3-Hexyl-1-hydroxy-7,8,9,10-tetrahydro-6,6,9-trimethyl-6/ <i>H/H</i> -dibenzo[b,d]pyran; Synhexyl;	
<i>/[o]</i> Other name: 2C-T-7 <i>///</i> ;		II. Peyote	7415
G. 2-(2,5-Dimethoxy-4-(n)-propylphenyl) ethanamine (2C-P)	7524	Meaning all parts of the plant presently classified botanically as <i>Lophophora williamsii</i> Lemaire, whether growing or not; the seeds thereof; any extract from any part of such plant; and every compound, manufacture, salt, derivative, mixture, or preparation of such plant, its seeds, or extracts;	
H. 2-(2,5-Dimethoxy-4-ethylphenyl) ethanamine (2C-E)	7509	JJ. <i>/N/N</i> -ethyl-3-piperidyl benzilate	7482
I. 2-(2,5-Dimethoxy-4-methylphenyl) ethanamine (2C-D)	7508	KK. <i>/N/N</i> -methyl-3-piperidyl benzilate	7484
J. 2-(2,5-Dimethoxy-4-nitro-phenyl) ethanamine (2C-N)	7521	LL. Psilocybin	7437
K. 2-(2,5-Dimethoxyphenyl) ethanamine (2C-H)	7517	MM. Psilocyn	7438
L. 2-(4-Chloro-2,5-dimethoxyphenyl) ethanamine (2C-C)	7519	NN. Tetrahydrocannabinols naturally contained in a plant of the genus <i>Cannabis</i> (<i>cannabis</i> 7370 plant), as well as synthetic equivalents of the substances contained in the <i>cannabis</i> plant or in the resinous extractives of such plant, and/or synthetic substances, derivatives and their isomers, or both, with similar chemical structure and pharmacological activity to those substances contained in the plant, such as the following:	
M. 2-(4-Ethylthio-2,5-dimethoxyphenyl) ethanamine (2C-T-2)	7385	(I) 1 cis or trans tetrahydrocannabinol and their optical isomers;	
N. 2-(4-Iodo-2,5-dimethoxyphenyl) ethanamine (2C-I)	7518	(II) 6 cis or trans tetrahydrocannabinol and their optical isomers;	
O. 2-(4-Isopropylthio)-2,5-dimethoxyphenyl) ethanamine (2C-T-4)	7532	(III) 3,4 cis or trans tetrahydrocannabinol and its optical isomers; and	
P. 4-methoxyamphetamine	7411	(IV) Since nomenclature of these substances is not internationally standardized, compounds of these structures, regardless of numerical designation of atomic positions are covered <i>/.</i> ;	
Some trade or other names: 4-methoxy-amethylphenethylamine; paramethoxyamphetamine; PMA;		OO. Ethylamine analog of phencyclidine	7455
Q. 5-methoxy-3,4-methylenedioxyamphetamine	7401	Some trade or other names: <i>/N/N</i> -ethyl-1-phenylcyclohexylamine, (1-phenylcyclohexyl) ethylamine, <i>/N/N</i> -(1-phenylcyclohexyl)-ethylamine, cyclohexamine, PCE;	
R. 4-methyl-2,5-dimethoxyamphetamine	7395	PP. Pyrrolidine analog of phencyclidine	7458
Some trade and other names: 4-methyl-2, 5-dimethoxy-amethylphenethylamine; DOM; and STP;		Some trade or other names: 1-(1-phenylcyclohexyl)-pyrrolidine PCPy, PHP;	
S. 3,4-methylenedioxyamphetamine	7400	QQ. Thiophene analog of phencyclidine	7470
T. 3,4-methylenedioxy-metham-phetamine (MDMA)	7405	Some trade or other names: 1-(1-(2-thienyl)-cyclohexyl)-piperidine, 2-thienyl analog of phencyclidine, TPCP, TCP;	
U. 3,4-methylenedioxy- <i>/N/N</i> -ethylamphetamine (also			

RR. 1-(1-(2-thienyl)cyclohexyl) pyrrolidine 7473
 Some other names: TCPyl.;
 SS. Salvia divinorum;
 TT. Salvinorin A;

UU. Synthetic cannabinoids: Unless specifically exempted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances, or which contains their salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

(I) Any compound structurally derived from 3-(1-naphthoyl)indole or 1/*H/H*-indol-3-yl-(1-naphthyl)methane by substitution at the nitrogen atom of the indole ring by alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(/*N/N*-methyl-2-piperidinyl)methyl, or 2-(4-morpholinyl)ethyl group, whether or not further substituted in the indole ring to any extent, whether or not substituted in the naphthyl ring to any extent. Including, but not limited to:

- (a) AM2201, or 1-(5-fluoropentyl)-3-(1-naphthoyl)indole 7201
- (b) JWH-007, or 1-pentyl-2-methyl-3-(1-naphthoyl)indole
- (c) JWH-015, or 1-propyl-2-methyl-3-(1-naphthoyl)indole
- (d) JWH-018, or 1-pentyl-3-(1-naphthoyl)indole 7118
- (e) JWH-019, or 1-hexyl-3-(1-naphthoyl)indole 7019
- (f) JWH-073, or 1-butyl-3-(1-naphthoyl)indole 7173
- (g) JWH-081, or 1-pentyl-3-(4-methoxy-1-naphthoyl)indole 7081
- (h) JWH-098, or 1-pentyl-2-methyl-3-(4-methoxy-1-naphthoyl)indole
- (i) JWH-122, or 1-pentyl-3-(4-methyl-1-naphthoyl)indole 7122
- (j) JWH-164, or 1-pentyl-3-(7-methoxy-1-naphthoyl)indole
- (k) JWH-200, or 1-(2-(4-(morpholinyl)ethyl))-3-(1-naphthoyl)indole 7200
- (l) JWH-210, or 1-pentyl-3-(4-ethyl-1-naphthoyl)indole
- (m) JWH-398, or 1-pentyl-3-(4-chloro-1-naphthoyl)indole 7398

(II) Any compound structurally derived from 3-(1-naphthoyl)pyrrole by substitution at the nitrogen atom of the pyrrole ring by alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(/*N/N*-methyl-2-piperidinyl)methyl, or 2-(4-morpholinyl)ethyl group, whether or not further substituted in the pyrrole ring to any extent, whether or not substituted in the naphthyl ring to any extent;

(III) Any compound structurally derived from 1-(1-naphthylmethyl)indene by substitution at the 3-position of the indene ring by alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(/*N/N*-methyl-2-piperidinyl)methyl, or 2-(4-morpholinyl)ethyl group, whether or not further substituted in the indene ring to any extent, whether or not substituted in the naphthyl ring to any extent;

(IV) Any compound structurally derived from 3-phenylacetylindole by substitution at the nitrogen atom of the indole ring by alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(/*N/N*-methyl-2-piperidinyl)methyl, or 2-(4-morpholinyl)ethyl group, whether or not further substituted in the indole ring to any extent, whether or not substituted in the phenyl ring to any extent. Including, but not limited to:

- (a) JWH-201, or 1-pentyl-3-(4-methoxyphenylacetyl)indole
- (b) JWH-203, or 1-pentyl-3-(2-chlorophenylacetyl)indole 7203
- (c) JWH-250, or 1-pentyl-3-(2-methoxyphenylacetyl)indole 6250
- (d) JWH-251, or 1-pentyl-3-(2-methylphenylacetyl)indole
- (e) RCS-8, or 1-(2-cyclohexylethyl)-3-(2-

methoxyphenylacetyl)indole 7008

(V) Any compound structurally derived from 2-(3-hydroxycyclohexyl)phenol by substitution at the 5-position of the phenolic ring by alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(/*N/N*-methyl-2-piperidinyl)methyl, or 2-(4-morpholinyl)ethyl group, whether or not substituted in the cyclohexyl ring to any extent. Including, but not limited to:

(a) CP 47,497 & homologues, or 2-[(1*R*,3*S*)-3-hydroxycyclohexyl]-5-(2-methyloctan-2-yl)phenol, where side chain n=5, and homologues where side chain n=4,6, or 7; 7297, 7298

(VI) Any compound containing a 3-(benzoyl)indole structure with substitution at the nitrogen atom of the indole ring by alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(/*N/N*-methyl-2-piperidinyl)methyl, or 2-(4-morpholinyl)ethyl group, whether or not further substituted in the indole ring to any extent and whether or not substituted in the phenyl ring to any extent. Including, but not limited to:

(a) AM-694, or 1-(5-fluoropentyl)-3-(2-iodobenzoyl)indole 7694

(b) RCS-4, or 1-pentyl-3-(4-methoxybenzoyl)indole (SR-19 and RCS-4) 7104

(VII) CP 50,556-1, or [(6*S*,6*aR*,9*R*,10*aR*)-9-hydroxy-6-methyl-3-[(2*R*)-5-phenylpentan-2-yl]oxy-5,6,6*a*,7,8,9,10,10*a*-octahydrophenanthridin-1-yl] acetate;

(VIII) HU-210, or (6*aR*,10*aR*)-9-(hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl)-6*a*,7,10,10*a*-tetrahydrobenzo[*c*]chromen-1-ol;

(IX) HU-211, or Dexanabinol, (6*aS*,10*aS*)-9-(hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl)-6*a*,7,10,10*a*-tetrahydrobenzo[*c*]chromen-1-ol; **and**

(X) Dimethylheptylpyran, or DMHP.

[4/.5. Depressants. Unless specifically excepted or unless listed in another schedule, any material compound, mixture, or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system, including its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

A. Gamma-hydroxybutyric acid and other names GHB; gamma-hydroxybutyrate; 4-hydroxybutyrate; 4-hydroxybutonic acid; sodium oxybate; sodium oxybutyrate; 2010

B. Mecloqualone 2572

C. Methaqualone 2565

[5/.6. Stimulants. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system, including its salts, isomers, and salts of isomers:

A. Aminorex 1585

Some trade or other names: aminoxaphen; 2-amino-5-phenyl-2-oxazoline; 4,5-dihydro-5-phenyl-2-oxazolamine;

B. *N/N*-benzylpiperazine 7493

//s/Some other names: BZP, 1-benzylpiperzaine//;

C. Cathinone 1235

///Some trade or other names: 2-amino-1-phenyl-1-propanone, alphaaminopropiophenone, 2-aminopropiophenone and norephedrone//;

D. Fenethylamine 1503

E. 3-Fluoromethcathinone 1233

F. 4-Fluoromethcathinone 1238

G. Mephedrone, or 4-methylmethcathinone 1248

H. Methcathinone 1237

Some trade or other names: 2-(methylamino)-propionophenone; alpha-(methylamino) propionophenone; 2-(methylamino)-1-phenylpropan-1-one; alpha-*N/N*-methylaminopropiophenone; monomethylpropion; ephedrone; *N/N*-methylcathinone; methylcathinine; AL-464; AL-422; AL-463; and URI 432;

I. 4-methoxymethcathinone

- J. cis-4-methylaminorex (cis-4,5-dihydro-4-methyl-5-phenyl-2-oxazolamine) 1590
- K. Methylenedioxypyrovalerone, MDPV, or (1-(1,3-Benzodioxol-5-yl)-2-(1-pyrrolidinyl)-1-pentanone) 7535
- L. Methylone, or 3,4-Methylenedioxymethcathinone 7540
- M. 4-Methyl- α -pyrrolidinobutiophenone, or MPBP
- N. */N/N*-ethylamphetamine 1475
- O. */N/N,N/N*-dimethylamphetamine 1480
- /s/Some other names: /N/N,N/N*- α -trimethylbenzeneethanamine; *N,N*- α -trimethylphenethylamine*/*;
- P. Quinolin-8-yl 1-pentyl-1*H*-indole-3-carboxylate (PB-22; QUPIC) 7222
- Q. Quinolin-8-yl 1-(5-fluoropentyl)-1*H*-indole-3-carboxylate (5-fluoro-PB-22; 5F-PB-22) 7225
- R. *N*-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(4-fluorobenzyl)-1*H*-indazole-3-carboxamide (AB-FUBINACA) 7012
- S. *N*-(1-amino-3, 3-dimethyl-1-oxobutan-2-yl)-1-pentyl-1*H*-indazole-3-carboxamide (ADB-PINACA) 7035
- [6.17.** A temporary listing of substances subject to emergency scheduling under federal law shall include any material, compound, mixture, or preparation which contains any quantity of the following substances:
- A. (1-pentyl-1*H*-indol-3-yl)(2,2,3,3-tetramethylcyclopropyl) methanone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: UR-144, 1-pentyl-3-(2,2,3,3-tetramethylcyclopropyl)indole) 7144
- B. [1-(5-fluoro-pentyl)-1*H*-indol-3-yl](2,2,3,3-tetramethylcyclopropyl) methanone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 5- fluoro-UR-144, 5-F-UR-144, XLR11, 1-(5-fluoro-pentyl)-3-(2,2,3,3-tetramethylcyclopropyl)indole) 7011
- C. *N*-(1-adamantyl)-1-pentyl-1*H*-indazole-3-carboxamide, its optical, positional, and geometric isomers, salts, and salts of isomer (Other names: APINACA, AKB48) 7048
- D. 2-(4-iodo-2,5-dimethoxyphenyl)-*N*-(2-methoxybenzyl)ethanamine, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 25I-NBOMe; 2C-I-NBOMe; 25I; Cimi-5) 7538
- E. 2-(4-chloro-2,5-dimethoxyphenyl)-*N*-(2-methoxybenzyl)ethanamine, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 25C-NBOMe; 2C-C-NBOMe; 25C; Cimi-82) 7537
- F. 2-(4-bromo-2,5- dimethoxyphenyl)-*N*-(2-methoxybenzyl)ethanamine, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 25B-NBOMe; 2C-B-NBOMe; 25B; Cimi-36) 7536
- G. 4-methyl-*N*-ethylcathinone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 4-MEC; 2-(ethylamino)-1-(4-methylphenyl)propan-1-one) 1249
- H. 4-methyl- α -pyrrolidinopropiophenone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 4-MePPP; MePPP; 4-methyl- α -pyrrolidinopropiophenone; 1-(4-methylphenyl)-2-(pyrrolidin-1-yl)-propan-1-one) 7498
- I. α -pyrrolidinopentiophenone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: α -PVP; α -pyrrolidinoveralphenone; 1-phenyl-2-(pyrrolidin-1-yl)pentan-1-one) 7545
- J. Butylone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: bk-MBDB; 1-(1,3-benzodioxol-5-yl)-2-(methylamino)butan-1-one) 7541
- K. Pentadron, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: α -methylaminovalerophenone; 2-(methylamino)-1-phenylpentan-1-one) 1246
- L. Pentylone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: bk-MBDP; 1-(1,3-benzodioxol-5-yl)-2-(methylamino)pentan-1-one) 7542
- M. Naphyrone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: naphthylpyrovalerone; 1-(naphthalen-2-yl)-2-(pyrrolidin-1-yl)pentan-1-one) 1258
- N. α -pyrrolidinobutiophenone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: α -PBP; 1-phenyl-2-(pyrrolidin-1-yl)butan-1-one) 7546
- O. *N*-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(cyclohexylmethyl)-1*H*-indazole-3-carboxamide, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: AB-CHMINACA) 7031
- P. *N*-(1-amino-3-methyl-1-oxobutan-2-yl)-1-pentyl-1*H*-indazole-3-carboxamide, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: AB-PINACA) 7023
- Q. [1-(5-fluoropentyl)-1*H*-indazol-3-yl](naphthalen-1-yl)methanone, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: THJ-2201) 7024
- /R. N*-(1-phenethylpiperidin-4-yl)-*N*-phenylbutyramide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other names: butyryl fentanyl) 9822]
- /S. /R. /N/N*-[1-[2-hydroxy-2-(thiophen-2-yl)ethyl]piperidin-4-yl]-/*N/N*-phenylpropionamide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other names: beta-hydroxythiofentanyl) 9836
- /T. /S. N*-(1-phenethylpiperidin-4-yl)-*N*-phenylacetamide, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: acetyl fentanyl) 9821
- /U. /T. /N/N*-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1-(cyclohexylmethyl)-1*H*-indazole-3-carboxamide, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: MAB-CHMINACA; ADB-CHMINACA) 7032
- /V. 3, 4-dichloro-N*-(2-(dimethylamino)cyclohexyl)-*N*-methylbenzamide (Other names: U-47700) 9547]
- /W. /U. N*-(1-phenethylpiperidin-4-yl)-*N*-phenylfuran-2-carboxamide (Other names: furanyl fentanyl) 9834
- V. methyl 2-(1-(5-fluoropentyl)-1*H*-indazole-3-carboxamido)-3,3-dimethylbutanoate, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 5F-ADB; 5F-MDMB-PINACA) (7034)
- W. methyl 2-(1-(5-fluoropentyl)-1*H*-indazole-3-carboxamido)-3-methylbutanoate, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 5F-AMB) (7033)

- X. *N*-(adamantan-1-yl)-1-(5-fluoropentyl)-1*H*-indazole-3-carboxamide, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 5F-APINACA, 5F-AKB48) (7049)
- Y. *N*-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1-(4-fluorobenzyl)-1*H*-indazole-3-carboxamide, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: ADB-FUBINACA) (7010)
- Z. methyl 2-(1-(cyclohexylmethyl)-1*H*-indole-3-carboxamido)-3,3-dimethylbutanoate, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: MDMB-CHMICA, MMB-CHMINACA) (7042)
- AA. methyl 2-(1-(4-fluorobenzyl)-1*H*-indazole-3-carboxamido)-3,3-dimethylbutanoate, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: MDMB-FUBINACA) (7020)
- BB. *N*-(4-fluorophenyl)-*N*-(1-phenethylpiperidin-4-yl)isobutyramide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other names: 4-fluoroisobutyryl fentanyl, *para*-fluoroisobutyryl fentanyl) (9824)
- CC. *N*-(1-phenethylpiperidin-4-yl)-*N*-phenylacrylamide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other names: acryl fentanyl, acryloylfentanyl) (9811)
- DD. *N*-(2-fluorophenyl)-*N*-(1-phenethylpiperidin-4-yl)propionamide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other names: *ortho*-fluorofentanyl, 2-fluorofentanyl) (9816)
- EE. *N*-(1-phenethylpiperidin-4-yl)-*N*-phenyltetrahydrofuran-2-carboxamide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other name: tetrahydrofuran fentanyl) (9843)
- FF. 2-methoxy-*N*-(1-phenethylpiperidin-4-yl)-*N*-phenylacetamide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other name: methoxyacetyl fentanyl) (9825)
- GG. methyl 2-(1-(4-fluorobenzyl)-1*H*-indazole-3-carboxamido)-3-methylbutanoate, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: FUB-AMB, MMB-FUBINACA, AMB-FUBINACA) (7021)
- HH. *N*-(1-phenethylpiperidin-4-yl)-*N*-phenylcyclopropanecarboxamide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other name: cyclopropyl fentanyl) (9845)
- II. *N*-(1-phenethylpiperidin-4-yl)-*N*-phenylpentanamide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other name: valeryl fentanyl) (9804)
- JJ. *N*-(4-fluorophenyl)-*N*-(1-phenethylpiperidin-4-yl)butyramide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other name: *para*-fluorobutyryl fentanyl) (9823)
- KK. *N*-(4-methoxyphenyl)-*N*-(1-phenethylpiperidin-4-yl)butyramide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other name: *para*-methoxybutyryl fentanyl) (9837)
- LL. *N*-(4-chlorophenyl)-*N*-(1-phenethylpiperidin-4-yl)isobutyramide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other name: *para*-chloroisobutyryl fentanyl) (9826)
- MM. *N*-(1-phenethylpiperidin-4-yl)-*N*-phenylisobutyramide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other name: isobutyryl fentanyl) (9827)
- NN. *N*-(1-phenethylpiperidin-4-yl)-*N*-phenylcyclopentanecarboxamide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other name: cyclopentyl fentanyl) (9847)
- OO. *N*-(2-fluorophenyl)-2-methoxy-*N*-(1-phenethylpiperidin-4-yl)acetamide, its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers (Other name: ocfentanyl) (9832)
- PP. Fentanyl-related substances, their isomers, esters, ethers, salts, and salts of isomers, esters, and ethers. 9850
(I) Fentanyl-related substance means any substance not otherwise listed under another Administration Controlled Substance Code Number, and for which no exemption or approval is in effect under section 505 of the Federal Food, Drug, and Cosmetic Act 21 U.S.C. 355, that is structurally related to fentanyl by one or more of the following modifications:
(a) Replacement of the phenyl portion of the phenethyl group by any monocycle, whether or not further substituted in or on the monocycle;
(b) Substitution in or on the phenethyl group with alkyl, alkenyl, alkoxy, hydroxyl, halo, haloalkyl, amino, or nitro groups;
(c) Substitution in or on the piperidine ring with alkyl, alkenyl, alkoxy, ester, ether, hydroxyl, halo, haloalkyl, amino, or nitro groups;
(d) Replacement of the aniline ring with any aromatic monocycle whether or not further substituted in or on the aromatic monocycle; and/or
(e) Replacement of the *N*-propionyl group by another acyl group;
- QQ. Naphthalen-1-yl 1-(5-fluoropentyl)-1*H*-indole-3-carboxylate, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: NM2201; CBL2201) (7221)
- RR. *N*-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(5-fluoropentyl)-1*H*-indazole-3-carboxamide, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 5F-AB-PINACA) (7025)
- SS. 1-(4-cyanobutyl)-*N*-(2-phenylpropan-2-yl)-1*H*-indazole-3-carboxamide, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 4-CN-CUMYL-BUTINACA; 4-cyano-CUMYL-BUTINACA; 4-CN-CUMYLBINACA; CUMYL-4CN-BINACA; SGT-78) (7089)
- TT. methyl 2-(1-(cyclohexylmethyl)-1*H*-indole-3-carboxamido)-3-methylbutanoate, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: MMB-CHMICA, AMB-CHMICA) (7044)
- UU. 1-(5-fluoropentyl)-*N*-(2-phenylpropan-2-yl)-1*H*-pyrrolo[2,3-*b*]pyridine-3-carboxamide, its optical, positional, and geometric isomers, salts, and salts of isomers (Other names: 5F-CUMYL-P7AICA) (7085)
- VV. *N*-Ethylpentylone, its optical, positional, and geometric isomers, salts, and salts of isomers

(Other names: ephylone, 1-(1,3-benzodioxol-5-yl)-2-(ethylamino)-pentan-1-one) (7543)

/7./8. Khat, to include all parts of the plant presently classified botanically as *catha edulis*, whether growing or not; the seeds thereof; any extract from any part of such plant; and every compound, manufacture, salt, derivative, mixture, or preparation of the plant, its seed, or extracts. 7032

(B) Schedule II shall consist of the drugs and other substances, by whatever official name, common or usual name, chemical name, or brand name designated, listed in this section. Each drug or substance has been assigned the Controlled Substances Code Number set forth opposite it.

1. Substances, vegetable origin, or chemical synthesis. Unless specifically excepted or unless listed in another schedule, Schedule II shall include any of the following substances whether produced directly or indirectly by extraction from substances of vegetable origin or independently by means of chemical synthesis or by a combination of extraction and chemical synthesis:

A. Opium and opiate; and any salt, compound, derivative, or preparation of opium or opiate, excluding apomorphine, thebaine-derived butorphanol, dextrophan, nalbuphine, nalmefene, naloxegol, naloxone, and naltrexone and their respective salts, but including the following:

(I) Raw opium	9600
(II) Opium extracts	9610
(III) Opium fluid	9620
(IV) Powdered opium	9639
(V) Granulated opium	9640
(VI) Tincture of opium	9630
(VII) Codeine	9050
(VIII) Dihydroetorphine	9334
(IX) Ethylmorphine	9190
(X) Etorphine hydrochloride	9059
(XI) Hydrocodone	9193
(XII) Hydromorphone	9150
(XIII) Metopon	9260
(XIV) Morphine	9300
(XV) Oripavine	9330
(XVI) Oxycodone	9143
(XVII) Oxymorphone	9652
(XVIII) Thebaine	9333

B. Any salt, compound, derivative, or preparation thereof which is chemically equivalent or identical with any of the substances referred to in subparagraph (1)(B)1.A. of this rule shall be included in Schedule II, except that these substances shall not include the isoquinoline alkaloids of opium;

C. Opium poppy and poppy straw[;] 9650

D. Coca leaves (9040) and any salt, compound, derivative, or preparation of coca leaves (including cocaine (9041) and ecgonine (9180) and their salts, isomers, derivatives, and salts of isomers and derivatives), and any salt, compound, derivative, or preparation thereof which is chemically equivalent or identical with any of these substances, except that the substances shall not include:

(I) Decocainized coca leaves or extraction of coca leaves, which extractions do not contain cocaine or ecgonine; or

(II) Ioflupane[;];

E. Concentrate of poppy straw (the crude extract of poppy straw in either liquid, solid, or powder form which contains the phenanthrene alkaloids of the opium poppy) 9670

2. Opiates. Unless specifically excepted or unless in another schedule any of the following opiates, including its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers whenever the existence of such isomers, esters, ethers, and salts is possible within the specific chemical designation, dextrophan, and levopropoxyphene excepted:

A. Alfentanil	9737
B. Alphaprodine	9010
C. Anileridine	9020
D. Bezitramide	9800

E. Bulk Dextropropoxyphene (Non-dosage Forms)	9273
F. Carfentanil	9743
G. Dihydrocodeine	9120
H. Diphenoxylate	9170
I. Fentanyl	9801
J. Isomethadone	9226
K. Levo-alphaacetylmethadol	9220

Some other names: levo-alphaacetylmethadol, levomethadyl acetate, LAAM

L. Levomethorphan	9648
M. Levorphanol	9210
N. Metazocine	9220
O. Methadone	9240
P. Methadone-Intermediate, 4-cyano-2-dimethylamino-4,4-diphenyl butane	9250
Q. Moramide-Intermediate, 2-methyl-3-morpholino-1,1-diphenylpropane-carboxylic acid	9254
R. Pethidine (Meperidine)	9802
S. Pethidine-Intermediate-A, 4-cyano-1-methyl-4-phenylpiperidine	9230
T. Pethidine-Intermediate-B, ethyl-4-phenylpiperidine-4-carboxylate	9232
U. Pethidine-Intermediate-C, 1-methyl-4-phenylpiperidine-4-carboxylic acid	9233
V. Phenazocine	9234
W. Piminodine	9715
X. Racemethorphan	9730
Y. Racemorphan	9732
Z. Remifentanil	9733
AA. Sufentanil	9739
BB. Tapentadol	9740
CC. Thiafentanil	9780
	9729

3. Stimulants. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system:

A. Amphetamine, its salts, optical isomers, and salts of its optical isomers	1100
B. Lisdexamfetamine, its salts, isomers, and salts of its isomers	1205
C. Methamphetamine, its salts, isomers, and salts of its isomers	1105
D. Phenmetrazine and its salts	1631
E. Methylphenidate	1724

4. Depressants. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system, including its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

A. Amobarbital	2125
B. Glutethimide	2550
C. Pentobarbital	2270
D. Phencyclidine	7471
E. Secobarbital	2315

5. Hallucinogenic substances:

A. Nabilone	7379
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Another name for nabilone: (±)trans-3-(1, 1-dimethylheptyl)-6, 6a,7,8,10,10a-hexahydro-1-hydroxy-6, 6-dimethyl-9H-dibenzo(b,d)pyran-9-one.

B. Dronabinol [(-)-delta-9-trans tetrahydrocannabinol] in an oral solution in a drug product approved for marketing by the United States Food and Drug Administration. (7365)

6. Immediate precursors. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances:

A. Immediate precursor to amphetamine and methamphetamine:

- (I) Phenylacetone 8501
Some trade or other names: phenyl-2- propanone; P2P; benzyl methyl ketone; methyl benzyl ketone;
- B. Immediate precursors to phencyclidine (PCP):
- (I) 1-phenylcyclohexylamine 7460
- (II) 1-piperidinocyclo-hexanecarbonitrile (PCC) 8603
- C. Immediate precursor to fentanyl:
- (I) 4-anilino-/N/N-phenethyl-4-piperidine (ANPP) 8333
7. Any material, compound, mixture, or preparation which contains any quantity of the following alkyl nitrites:
- A. Amyl nitrite;
- B. Butyl nitrite.
- (E) Schedule V shall consist of the drugs and other substances, by whatever official name, common or usual name, chemical name, or brand name designated, listed in this subsection.
1. Narcotic drugs containing nonnarcotic active medicinal ingredients. Any compound, mixture, or preparation containing any of the following narcotic drugs, or their salts calculated as the free anhydrous base or alkaloid, in limited quantities as follows, which shall include one (1) or more nonnarcotic active medicinal ingredients in sufficient proportion to confer upon the compound, mixture, or preparation valuable medicinal qualities other than those possessed by the narcotic drug alone:
- A. Not more than two hundred milligrams (200 mg) of codeine per one hundred milliliters (100 mL) or per one hundred grams (100 g);
- B. Not more than one hundred milligrams (100 mg) of dihydrocodeine per one hundred milliliters (100 mL) or per one hundred grams (100 g);
- C. Not more than one hundred milligrams (100 mg) of ethylmorphine per one hundred milliliters (100 mL) or per one hundred grams (100 g)/.;
- D. Not more than two and five-tenths milligrams (2.5 mg) of diphenoxylate and not less than twenty-five micrograms (25 mcg) of atropine sulfate per dosage unit/.;
- E. Not more than one hundred milligrams (100 mg) of opium per one hundred milliliters (100 mL) or per one hundred grams (100 g)/.; and
- F. Not more than five-tenths milligram (0.5 mg) of difenoxin (DEA Drug Code No. 9168) and not less than twenty-five micrograms (25 mcg) of atropine sulfate per dosage unit.
2. Stimulants. Unless specifically exempted or excluded or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system including its salts, isomers, and salts of isomers:
- A. Pyrovalerone 1485
3. Any compound, mixture, or preparation containing any detectable quantity of pseudoephedrine or its salts or optical isomers, or salts of optical isomers or any compound, mixture, or preparation containing any detectable quantity of ephedrine or its salts or optical isomers, or salts of optical isomers if the drug preparations are starch-based solid dose forms, if such preparations are sold over the counter without a prescription. The following drug preparations containing ephedrine and pseudoephedrine are not scheduled controlled substances:
- A. Drug preparations in liquid form;
- B. Drug preparations that require a prescription in order to be dispensed.
4. Unless specifically exempted or excluded or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system, including its salts:
- A. Ezogabine [N-[2-amino-4(4- fluorobenzylamino)-phenyl]-carbamic acid ethyl ester] 2779
- B. Lacosamide [(R)-2-acetoamido-N-benzyl-3-methoxy-propionamide] 2746
- C. Pregabalin [(S)-3-(aminomethyl)-5-methylhexanoic acid] 2782

- D. Brivaracetam ((2S)-2-[(4R)-2-oxo-4-propylpyrrolidin-1-yl]butanamide) (also referred to as BRV; UCB-34714; Briviact) 2710

5. Approved cannabidiol drugs.

- A. A drug product in finished dosage formulation that has been approved by the U.S. Food and Drug Administration that contains cannabidiol (2-[1R-3-methyl-6R-(1-methylethenyl)-2-cyclohexen-1-yl]-5-pentyl-1,3-benzenediol) derived from cannabis and no more than one tenth percent (0.1%) (w/w) residual tetrahydrocannabinols 7367

AUTHORITY: sections 195.015 and 195.195, RSMo 2016. Material found in this rule previously filed as 19 CSR 30-1.010. Original rule filed April 14, 2000, effective Nov. 30, 2000. Amended: Filed Jan. 31, 2003, effective July 30, 2003. Amended: Filed Sept. 30, 2016, effective May 30, 2017. Emergency amendment filed Oct. 25, 2018, effective Nov. 4, 2018, expires May 2, 2019. Amended: Filed Oct. 25, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment, by contacting Michael Boeger with the Missouri Department of Health and Senior Services, Bureau of Narcotics and Dangerous Drugs, PO Box 570, Jefferson City, MO 65102-0570. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION Division 100—Insurer Conduct Chapter 6—Privacy of Consumer Information

PROPOSED AMENDMENT

20 CSR 100-6.100 Privacy of Financial Information. The director is amending sections (1), (2), (3), (4), and (5) and deleting Appendix 1 which follows the rule in the *Code of State Regulations*.

PURPOSE: This amendment reflects changes to the federal Gramm-Leach-Bliley Act made by Congress through the enactment of the Fixing America's Surface Transportation Act (FAST) in 2015 (Pub. L. No. 114-94). These changes eliminated the GLBA requirement for financial institutions to provide annual privacy notices about treatment of nonpublic personal information under certain conditions. These GLBA changes eliminated duplicative and costly notification requirements for financial institutions, including insurance companies. Amending this rule aligns state law with federal law.

(1) Definitions. As used in this rule, unless the context requires otherwise:

(B) "Clear and conspicuous" means that a notice is reasonably understandable and designed to call attention to the nature and significance of the information in the notice. For example:

1. *[Reasonably understandable.]* A licensee makes its notice reasonably understandable if it:

A. Presents the information in the notice in clear, concise sentences, paragraphs, and sections;

B. Uses short explanatory sentences or bullet lists whenever possible;

C. Uses definite, concrete, everyday words and active voice whenever possible;

D. Avoids multiple negatives;

E. Avoids legal and highly technical business terminology whenever possible; and

F. Avoids explanations that are imprecise and readily subject to different interpretations.

2. *[Designed to call attention.]* A licensee designs its notice to call attention to the nature and significance of the information in it if the licensee¹—

A. Uses a plain-language heading to call attention to the notice;

B. Uses a typeface and type size that are easy to read;

C. Provides wide margins and ample line spacing;

D. Uses boldface or italics for key words; and

E. In a form that combines the licensee's notice with other information, uses distinctive type size, style, and graphic devices, such as shading or sidebars.

3. *[Notices on web sites.]* If a licensee provides a notice on a web page, the licensee designs its notice to call attention to the nature and significance of the information in it if the licensee uses text or visual cues to encourage scrolling down the page, if necessary, to view the entire notice and ensure that other elements on the web site (such as text, graphics, hyperlinks or sound) do not distract attention from the notice, and the licensee either²—

A. Places the notice on a screen that consumers frequently access, such as a page on which transactions are conducted; or

B. Places a link on a screen that consumers frequently access, such as a page on which transactions are conducted, that connects directly to the notice and is labeled appropriately to convey the importance, nature, and relevance of the notice.

(F) "Consumer" means an individual who seeks to obtain, obtains, or has obtained an insurance product or service from a licensee that is to be used primarily for personal, family or household purposes, and about whom the licensee has nonpublic personal information, or that individual's legal representative. For example:

1. An individual who provides nonpublic personal information to a licensee in connection with obtaining, or seeking to obtain, financial, investment, or economic advisory services relating to an insurance product or service is a consumer regardless of whether the licensee establishes an ongoing advisory relationship;

2. An applicant for insurance prior to the inception of insurance coverage is a licensee's consumer;

3. An individual who is a consumer of another financial institution is not a licensee's consumer solely because the licensee is acting as agent for, or provides processing or other services to, that financial institution;

4. An individual is a licensee's consumer if:

A. The individual is:

(I) A beneficiary of a life insurance policy underwritten by the licensee;

(II) A claimant under an insurance policy or certificate issued by the licensee³, *other than a third-party claimant*;

(III) An insured or an annuitant under an insurance policy or an annuity, respectively, issued by the licensee;

(IV) A mortgagor of a mortgage covered under a mortgage insurance policy; and

B. The licensee discloses nonpublic personal financial information about the individual to a nonaffiliated third party other than as permitted under subsections (4)(A), (4)(B), and (4)(C) of this rule;

5. Provided that the licensee provides the initial, annual, and revised notices under subsections (2)(A), (2)(B), and (2)(E) of this rule to the plan sponsor, group, or blanket insurance policyholder, or group annuity contractholder, and further provided that the licensee does not disclose to a nonaffiliated third party nonpublic personal

financial information about such an individual other than as permitted under subsections (4)(A), (4)(B), and (4)(C) of this rule, an individual is not the consumer of the licensee solely because he or she is:

A. A participant or a beneficiary of an employee benefit plan that the licensee administers, or sponsors, or for which the licensee acts as a trustee, insurer, or fiduciary;

B. Covered under a group or blanket insurance policy or group annuity contract issued by the licensee;

6. The individuals described in subparagraphs (1)(F)5.A. and (1)(F)5.B. are consumers of a licensee if the licensee does not meet all the conditions of paragraph (1)(F)5. In no event shall the individuals, solely by virtue of the status described in subparagraphs (1)(F)5.A. and (1)(F)5.B. of this subsection, be deemed to be customers for purposes of this rule;

7. An individual is not a licensee's consumer solely because he or she is a beneficiary of a trust for which the licensee is a trustee;

8. An individual is not a licensee's consumer solely because he or she has designated the licensee as trustee for a trust.

(H) "Control" means:

1. Ownership, control, or power to vote twenty-five percent (25%) or more of the outstanding shares of any class of voting security of the company, directly or indirectly, or acting through one (1) or more other persons;

2. Control in any manner over the election of a majority of the directors, trustees, or general partners (or individuals exercising similar functions) of the company; or

3. The power to exercise, directly or indirectly, a controlling influence over the management or policies of the company, as the *[commissioner]* director determines.

(J) "Customer relationship" means a continuing relationship between a consumer and a licensee under which the licensee provides one or more insurance products or services to the consumer that are to be used primarily for personal, family, or household purposes. *[Examples.]*

1. A consumer has a continuing relationship with a licensee if⁴—

A. The consumer is a current policyholder of an insurance product issued by or through the licensee; or

B. The consumer obtains financial, investment, or economic advisory services relating to an insurance product or service from the licensee for a fee.

2. A consumer does not have a continuing relationship with a licensee if⁵—

A. The consumer applies for insurance but does not purchase the insurance;

B. The licensee sells the consumer airline travel insurance in an isolated transaction;

C. The individual is no longer a current policyholder of an insurance product or no longer obtains insurance services with or through the licensee;

D. The consumer is a beneficiary or claimant under a policy and has submitted a claim under a policy choosing a settlement option involving an ongoing relationship with the licensee;

E. The consumer is a beneficiary or a claimant under a policy and has submitted a claim under a policy choosing a lump sum settlement option;

F. The customer's policy is lapsed, expired, or otherwise inactive or dormant under the licensee's business practices, and the licensee has not communicated with the customer about the relationship for a period of twelve (12) consecutive months, other than annual privacy notices, material required by law or rule, communication at the direction of a state or federal authority, or promotional materials;

G. The individual is an insured or an annuitant under an insurance policy or annuity, respectively, but is not the policyholder or owner of the insurance policy or annuity; or

H. For the purposes of this rule, the individual's last known address according to the licensee's records is deemed invalid. An

address of record is deemed invalid if mail sent to that address by the licensee has been returned by the postal authorities as undeliverable and if subsequent attempts by the licensee to obtain a current valid address for the individual have been unsuccessful.

(M) "Insurance product or service" means any product or service that is offered by a licensee pursuant to the insurance laws of this state. *Insurance service includes*, including a licensee's evaluation, brokerage, or distribution of information that the licensee collects in connection with a request or an application from a consumer for */a/* an insurance product or service.

(N) "Licensee" means all licensed insurers, producers, and other persons licensed *[or required to be licensed, or authorized or required to be authorized, or registered or required to be registered]*, authorized, or registered, or required to be licensed, authorized, or registered by the director pursuant to the laws of this state.

1. A licensee is not subject to the notice and opt out requirements for nonpublic personal financial information set forth in sections (1), (2), (3), and (4) of this rule if the licensee is an employee, agent, or other representative of another licensee ("the principal") and:

A. The principal otherwise complies with, and provides *[the]* notices *[required by]* pursuant to the provisions of this rule; and

B. The licensee does not disclose any nonpublic personal information to any other person other than the principal or its affiliates in a manner permitted by this rule, other than as permitted by subparagraph (4)(B)1.E.

2. Nonadmitted insurers.

A. Subject to subparagraph (1)(N)1.B., "licensee" *[shall]* also include a nonadmitted insurer that accepts business placed through a licensed surplus lines broker in this state, but only in regard to the surplus lines placements placed pursuant to Chapter 384, RSMo.

B. A surplus lines broker or surplus lines insurer *[shall be]* deemed to be in compliance with the notice and opt out requirements for nonpublic personal financial information set forth in sections (1), (2), (3), and (4) of this rule provided~~:/~~—

(I) The broker or insurer does not disclose nonpublic personal information of a consumer or a customer to nonaffiliated third parties for any purpose, including joint servicing or marketing under subsection (4)(A) of this rule, except as permitted by subsection~~s~~/ (4)(B) or (4)(C) of this rule; and

(II) The broker or insurer delivers a notice to the consumer at the time a customer relationship is established on which the following is printed in sixteen (16)-point type:

PRIVACY NOTICE

NEITHER THE U.S. BROKERS THAT HANDLED THIS INSURANCE NOR THE INSURERS THAT HAVE UNDERWRITTEN THIS INSURANCE WILL DISCLOSE NONPUBLIC PERSONAL INFORMATION CONCERNING THE BUYER TO NONAFFILIATES OF THE BROKERS OR INSURERS EXCEPT AS PERMITTED BY LAW.

(O) "Nonaffiliated third party."

[1. "Nonaffiliated third party" means a/Any person except:/

/A. A/a licensee's affiliate~~/~~ or

/B. A/a person employed jointly by a licensee and any company that is not the licensee's affiliate (but nonaffiliated third party includes the other company that jointly employs the person).

[2. Nonaffiliated third party includes a/Any company that is an affiliate solely by virtue of the direct or indirect ownership or control of the company by the licensee or its affiliate in conducting merchant banking or investment banking activities of the type described in section 4(k)(4)(H) or insurance company investment activities of the type described in section 4(k)(4)(I) of the federal Bank Holding Company Act (12 U.S.C. 1843(k)(4)(H) and (I)) is a

nonaffiliated third party.

(Q) "Nonpublic personal financial information."

1. "Nonpublic personal financial information" means~~/~~:

A./ Personally identifiable financial information; and

/B. A/any list, description, or other grouping of consumers (and publicly available information pertaining to them) that is derived using any personal~~/ly~~/ identifiable financial information that is not publicly available.

2. Nonpublic personal financial information does not include~~/~~—

A. Publicly available information, except as included on a list described in subparagraph (1)(Q)1.B.; or

B. Any list, description, or other grouping of consumers (and publicly available information pertaining to them) that is derived without using any personally identifiable financial information that is not publicly available.

[(I) Examples of lists.]

[(a)/(I) Nonpublic personal financial information includes any list of individuals' names and street addresses that is derived in whole or in part using personal~~/ly~~/ identifiable financial information that is not publicly available, such as account numbers.

[(b)/(II) Nonpublic personal financial information does not include any list of individuals' names and addresses that contains only publicly available information, is not derived in whole or in part using personal~~/ly~~/ identifiable financial information that is not publicly available, and is not disclosed in a manner that indicates that any of the individuals on the list is a consumer of a financial institution.

(R) "Personal~~/ly~~/ identifiable financial information."

[1. "Personally identifiable financial information"] means any information:

/A./1.A consumer provides to a licensee to obtain an insurance product or service from the licensee;

/B./2. About a consumer resulting from a transaction involving an insurance product or service between a licensee and a consumer; or

/C./3. The licensee otherwise obtains about a consumer in connection with providing an insurance product or service to that consumer.

[2. Examples.]

/A./4. [Information included.] Personal~~/ly~~/ identifiable financial information includes~~/~~—

[(I)/A. Information a consumer provides to a licensee on an application to obtain an insurance product or service;

[(II)/B. Account balance information and payment history;

[(III)/C. The fact that an individual is or has been one of the licensee's customers or has obtained an insurance product or service from the licensee;

[(IV)/D. Any information about the licensee's consumer if it is disclosed in a manner that indicates that the individual is or has been the licensee's consumer;

[(V)/E. Any information that a consumer provides to a licensee or that the licensee or its agent otherwise obtains in connection with collecting on a loan or servicing a loan;

[(VI)/F. Any information the licensee collects through an Internet cookie (an information-collecting device from a web server); and

[(VII)/G. Information from a consumer report.

/B./5. [Information not included.] Personally identifiable financial information does not include~~/~~—

[(I)/A. A list of names and addresses of customers of an entity that is not a financial institution; and

[(II)/B. Information that does not identify a consumer, such as aggregate information or blind data that does not contain personal identifiers such as account numbers, names, or addresses.

(S) "Publicly available information~~/~~."

[1. "Publicly available information"] means any information that a licensee has a reasonable basis to believe is lawfully made available to the general public from:/

A. F/federal, state, or local government records;

/B. W/widely distributed media; or

[C. D]disclosures to the general public [that are required to be] made [by] pursuant to federal, state, or local law.

[2.1. Reasonable basis.] A licensee has a reasonable basis to believe that information is lawfully made available to the general public if the licensee has taken steps to determine:/—

A. That the information is of the type that is available to the general public; and

B. Whether an individual can direct that the information not be made available to the general public and, if so, that the licensee's consumer has not done so.

[3.2. Examples.

A. [Government records.] Publicly available information in government records includes information in government real estate records and security interest filings.

B. [Widely distributed media.] Publicly available information from widely distributed media includes information from a telephone book, a television or radio program, a newspaper, or a web site that is available to the general public on an unrestricted basis. A web site is not restricted merely because an Internet service provider or a site operator requires a fee or a password, so long as access is available to the general public.

C. Reasonable basis.

(I) A licensee has a reasonable basis to believe that mortgage information is lawfully made available to the general public if the licensee has determined that the information is of the type included on the public record in the jurisdiction where the mortgage would be recorded.

(II) A licensee has a reasonable basis to believe that an individual's telephone number is lawfully made available to the general public if the licensee has located the telephone number in the telephone book or the consumer has informed you that the telephone number is not unlisted.

(T) "Third-party claimant" has the same meaning as in subsection 20 CSR 100-1.010(1)(H).

(2) Privacy and Opt Out Notices For Financial Information.

(A) Initial Privacy Notice to Consumers [Required].

1. [Initial notice requirement.] A licensee shall provide a clear and conspicuous notice that accurately reflects its privacy policies and practices to:/—

A. [Customer.] An individual who becomes the licensee's customer, not later than when the licensee establishes a customer relationship, except as provided in paragraph (2)(A)5.; and

B. [Consumer.] A consumer, before the licensee discloses any nonpublic personal financial information about the consumer to any nonaffiliated third party, if the licensee makes a disclosure other than as authorized by subsections (4)(B) and (4)(C).

2. [When initial notice to a consumer is not required.] A licensee is not required to provide an initial notice to a consumer under subparagraph (2)(A)1.B. if:

A. The licensee does not disclose any nonpublic personal financial information about the consumer to any nonaffiliated third party, other than as authorized by subsections (4)(B) and (4)(C), and the licensee does not have a customer relationship with the consumer; or

B. A notice has been provided by an affiliated licensee, as long as the notice clearly identifies all licensees to whom the notice applies and is accurate with respect to the licensee and the other institutions.

3. When the licensee establishes a customer relationship.

A. [General rule.] A licensee establishes a customer relationship at the time the licensee and the consumer enter into a continuing relationship.

B. [Examples of establishing customer relationship.] A licensee establishes a customer relationship when the consumer:/—

(I) Becomes a policyholder of a licensee that is an insurer when the insurer delivers an insurance policy or contract to the consumer, or in the case of a licensee that is an insurance producer or insurance broker, obtains insurance through that licensee; or

(II) Agrees to obtain financial, economic, or investment advisory services relating to insurance products or services for a fee from the licensee.

4. [Existing customers.] When an existing customer obtains a new insurance product or service from a licensee that is to be used primarily for personal, family, or household purposes, the licensee satisfies the initial notice requirements of paragraph (2)(A)1. as follows:

A. The licensee may provide a revised policy notice, under subsection (2)(E), that covers the customer's new insurance product or service; or

B. If the initial, revised or annual notice that the licensee most recently provided to that customer was accurate with respect to the new insurance product or service, the licensee does not need to provide a new privacy notice under paragraph (2)(A)1.

5. Exceptions to allow subsequent delivery of notice.

A. A licensee may provide the initial notice [required by] pursuant to paragraph (2)(A)1. of this section within a reasonable time after the licensee establishes a customer relationship if:/—

(I) Establishing the customer relationship is not at the customer's election; or

(II) Providing notice not later than when the licensee establishes a customer relationship would substantially delay the customer's transaction and the customer agrees to receive the notice at a later time.

B. Examples of exceptions.

(I) [Not at customer's election.] Establishing a customer relationship is not at the customer's election if a licensee acquires or is assigned a customer's policy from another financial institution or residual market mechanism and the customer does not have a choice about the licensee's acquisition or assignment.

(II) [Substantial delay of customer's transaction.] Providing notice not later than when a licensee establishes a customer relationship would substantially delay the customer's transaction when the licensee and the individual agree over the telephone to enter into a customer relationship involving prompt delivery of the insurance product or service.

(III) [No substantial delay of customer's transaction.] Providing notice not later than when a licensee establishes a customer relationship would not substantially delay the customer's transaction when the relationship is initiated in person at the licensee's office or through other means by which the customer may view the notice, such as on a web site.

6. [Delivery.] When a licensee is required to deliver an initial privacy notice by this section, the licensee shall deliver it according to subsection (2)(F). If the licensee uses a short-form initial notice for non-customers according to paragraph (2)(C)4., the licensee may deliver its privacy notice according to subparagraph (2)(C)4.C.

(B) Annual Privacy Notice to Customers [Required].

1. [General rule.] A licensee shall provide a clear and conspicuous notice to customers that accurately reflects its privacy policies and practices not less than annually during the continuation of the customer relationship. Annually means at least once in any period of twelve (12) consecutive months during which that relationship exists. A licensee may define the twelve (12)-consecutive-month period, but the licensee shall apply it to the customer on a consistent basis.

2. [Example.] A licensee provides a notice annually if it defines the twelve (12)-consecutive-month period as a calendar year and provides the annual notice to the customer once in each calendar year following the calendar year in which the licensee provided the initial notice. For example, if a customer opens an account on any day of year 1, the licensee [shall] will provide an annual notice to that customer by December 31 of year 2.

3. A licensee that provides nonpublic personal information to nonaffiliated third parties only in accordance with subsections (4)(A), (4)(B), or (4)(C) and has not changed its policies and practices with regard to disclosing nonpublic personal information from the policies and practices that were disclosed in the

most recent disclosure sent to consumers in accordance with this subsection or subsection (2)(A) is not required to provide an annual disclosure under this section until such time as the licensee fails to comply with any criteria described in this paragraph.

[3.]4. *[Termination of customer relationship.]* A licensee is not required to provide an annual notice to a former customer. A former customer is an individual with whom a licensee no longer has a continuing relationship.

A. Examples.

(I) A licensee no longer has a continuing relationship with an individual if the individual no longer is a current policyholder of an insurance product or no longer obtains insurance services with or through the licensee.

(II) A licensee no longer has a continuing relationship with an individual if the individual's policy is lapsed, expired, or otherwise inactive or dormant under the licensee's business practices, and the licensee has not communicated with the customer about the relationship for a period of twelve (12) consecutive months, other than to provide annual privacy notices, material *[required by] provided pursuant to law or rule, or promotional materials.*

(III) For the purposes of this rule, a licensee no longer has a continuing relationship with an individual if the individual's last known address according to the licensee's records is deemed invalid. An address of record is deemed invalid if mail sent to that address by the licensee has been returned by the postal authorities as undeliverable, and if subsequent attempts by the licensee to obtain a current valid address for the individual have been unsuccessful.

(IV) A licensee no longer has a continuing relationship with a customer in the case of providing real estate settlement services, at the time the customer completes execution of all documents related to the real estate closing, payment for those services has been received, or the licensee has completed all of its responsibilities with respect to the settlement, including filing documents on the public record, whichever is later.

4. *[Delivery.]* When a licensee is required by this section to deliver an annual privacy notice, the licensee shall deliver it according to subsection (2)(F).

(C) Information to Be Included in Privacy Notices.

1. *[General rule.]* The initial, annual, and revised privacy notices that a licensee provides under subsections (2)(A), (2)(B) and (2)(E) shall include each of the following items of information, in addition to any other information the licensee wishes to provide, that applies to the licensee and to the consumers to whom the licensee sends its privacy notice:

A. The categories of nonpublic personal financial information that the licensee collects;

B. The categories of nonpublic personal financial information that the licensee discloses;

C. The categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal financial information, other than those parties to whom the licensee discloses information under subsections (4)(B) and (4)(C);

D. The categories of nonpublic personal financial information about the licensee's former customers that the licensee discloses and the categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal financial information about the licensee's former customers, other than those parties to whom the licensee discloses information under subsections (4)(B) and (4)(C);

E. If a licensee discloses nonpublic personal financial information to a nonaffiliated third party under subsection (4)(A) (and no other exception in subsections (4)(B) and (4)(C) applies to that disclosure), a separate description of the categories of information the licensee discloses and the categories of third parties with whom the licensee has contracted;

F. An explanation of the consumer's right under paragraph (3)(A)1. to opt out of the disclosure of nonpublic personal financial information to nonaffiliated third parties, including the methods by

which the consumer may exercise that right at that time;

G. Any disclosures that the licensee makes under section 603(d)(2)(A)(iii) of the federal Fair Credit Reporting Act (15 U.S.C. 1681a(d)(2)(A)(iii)) (that is, notices regarding the ability to opt out of disclosures of information among affiliates);

H. The licensee's policies and practices with respect to protecting the confidentiality and security of nonpublic personal information; and

I. Any disclosure that the licensee makes under paragraph (2)(C)2.

2. *[Description of parties subject to exceptions.]* If a licensee discloses nonpublic personal financial information as authorized under subsections (4)(B) and (4)(C), the licensee is not required to list those exceptions in the initial or annual privacy notices *[required by] provided pursuant to subsections (2)(A) and (2)(B).* When describing the categories of parties to whom disclosure is made, the licensee is required to state only that it makes disclosures to other affiliated or nonaffiliated third parties, as applicable, as permitted by law.

3. Examples.

A. *[Categories of nonpublic personal financial information that the licensee collects.]* A licensee satisfies the requirement to categorize the nonpublic personal financial information it collects if the licensee categorizes it according to the source of the information, as applicable:

(I) Information from the consumer;

(II) Information about the consumer's transactions with the licensee or its affiliates;

(III) Information about the consumer's transactions with nonaffiliated third parties; and

(IV) Information from a consumer reporting agency.

B. Categories of nonpublic personal financial information a licensee discloses.

(I) A licensee satisfies the requirement to categorize nonpublic personal financial information it discloses if the licensee categorizes the information according to source, as described in subparagraph (2)(C)3.A., as applicable, and provides a few examples to illustrate the types of information in each category. These might include:—

(a) Information from the consumer, including application information, such as assets and income and identifying information, such as name, address and social security number;

(b) Transaction information, such as information about balances, payment history and parties to the transaction; and

(c) Information from consumer reports, such as a consumer's creditworthiness and credit history.

(II) A licensee does not adequately categorize the information that it discloses if the licensee uses only general terms, such as transaction information about the consumer.

(a) If a licensee reserves the right to disclose all of the nonpublic personal financial information about consumers that it collects, the licensee may simply state that fact without describing the categories or examples of nonpublic personal information that the licensee discloses.

C. Categories of affiliates and nonaffiliated third parties to whom the licensee discloses.

(I) A licensee satisfies the requirement to categorize the affiliates and nonaffiliated third parties to which the licensee discloses nonpublic personal financial information about consumers if the licensee identifies the types of businesses in which they engage.

(II) Types of businesses may be described by general terms only if the licensee uses a few illustrative examples of significant lines of business. For example, a licensee may use the term financial products or services if it includes appropriate examples of significant lines of businesses, such as life insurer, automobile insurer, consumer banking or securities brokerage.

(III) A licensee also may categorize the affiliates and nonaffiliated third parties to which it discloses nonpublic personal financial information about consumers using more detailed categories.

D. Disclosures under exception for service providers and joint marketers. If a licensee discloses nonpublic personal financial information under the exception in subsection (4)(A) to a nonaffiliated third party to market products or services that it offers alone or jointly with another financial institution, the licensee satisfies the disclosure requirement of subparagraph (2)(C)1.E. if it:

(I) Lists the categories of nonpublic personal financial information it discloses, using the same categories and examples the licensee used to meet the requirements of subparagraph (2)(C)1.B., as applicable; and

(II) States whether the third party is:

(a) A service provider that performs marketing services on the licensee's behalf or on behalf of the licensee and another financial institution; or

(b) A financial institution with whom the licensee has a joint marketing agreement.

E. *[Simplified notices.]* If a licensee does not disclose, and does not wish to reserve the right to disclose, nonpublic personal financial information about customers or former customers to affiliates or nonaffiliated third parties except as authorized under subsections (4)(B) and (4)(C), the licensee may simply state that fact, in addition to the information it *[shall]* provides under subparagraphs (2)(C)1.A., (2)(C)1.H., (2)(C)1.I., and paragraph (2)(C)2.

F. *[Confidentiality and security.]* A licensee describes its policies and practices with respect to protecting the confidentiality and security of nonpublic personal financial information if it *[does both of the following]*:

(I) *D*/describes in general terms who is authorized to have access to the information; and

(III) *S*/states whether the licensee has security practices and procedures in place to ensure the confidentiality of the information in accordance with the licensee's policy. The licensee is not required to describe technical information about the safeguards it uses.

4. Short-form initial notice with opt out notice for non-customers.

A. A licensee may satisfy the initial notice requirements in subparagraph (2)(A)1.B. and paragraph (2)(D)4. for a consumer who is not a customer by providing a short-form initial notice at the same time as the licensee delivers an opt out notice *[as required in] pursuant to* subsection (2)(D).

B. A short-form initial notice shall *:/—*:

(I) Be clear and conspicuous;

(II) State that the licensee's privacy notice is available upon request; and

(III) Explain a reasonable means by which the consumer may obtain that notice.

C. The licensee shall deliver its short-form initial notice according to subsection (2)(F). The licensee is not required to deliver its privacy notice with its short-form initial notice. The licensee instead may simply provide the consumer a reasonable means to obtain its privacy notice. If a consumer who receives the licensee's short-form notice requests the licensee's privacy notice, the licensee shall deliver its privacy notice according to subsection (2)(F).

D. *[Examples of obtaining privacy notice.]* The licensee provides a reasonable means by which a consumer may obtain a copy of its privacy notice if the licensee *:/—*:

(I) Provides a toll-free telephone number that the consumer may call to request the notice; or

(II) For a consumer who conducts business in person at the licensee's office, maintains copies of the notice on hand that the licensee provides to the consumer immediately upon request.

5. *[Future disclosures.]* The licensee's notice may include *:/—*:

A. Categories of nonpublic personal financial information that the licensee reserves the right to disclose in the future, but does not currently disclose; and

B. Categories of affiliates or nonaffiliated third parties to whom the licensee reserves the right in the future to disclose, but to whom the licensee does not currently disclose, nonpublic personal

financial information.

6. *[Sample clauses.]* Sample clauses illustrating some of the notice content *[required by]* described in this section are *[included herein as Appendix A of this rule] are available on the department's website at www.insurance.mo.gov.*

(D) Form of Opt Out Notice to Consumers and Opt Out Methods.

1. Form of opt out notice. If a licensee is required to provide an opt out notice under paragraph (3)(A)1., it shall provide a clear and conspicuous notice to each of its consumers that accurately explains the right to opt out under that section*/. The notice shall state:/, and which states:*

A. That the licensee discloses or reserves the right to disclose nonpublic personal financial information about its consumer to a nonaffiliated third party;

B. That the consumer has the right to opt out of that disclosure; and

C. A reasonable means by which the consumer may exercise the opt out right.

2. Examples.

A. *[Adequate opt out notice.]* A licensee provides adequate notice that the consumer can opt out of the disclosure of nonpublic personal financial information to a nonaffiliated third party if the licensee *:/—*:

(I) Identifies all of the categories of nonpublic personal financial information that it discloses or reserves the right to disclose, and all of the categories of nonaffiliated third parties to which the licensee discloses the information, as described in subparagraphs (2)(C)1.B. and (2)(C)1.C., and states that the consumer can opt out of the disclosure of that information; and

(II) Identifies the insurance products or services that the consumer obtains from the licensee, either singly or jointly, to which the opt out direction would apply.

B. *[Reasonable opt out means.]* A licensee provides a reasonable means to exercise an opt out right if it *:/—*:

(I) Designates check-off boxes in a prominent position on the relevant forms with the opt out notice;

(II) Includes a reply form together with the opt out notice;

(III) Provides an electronic means to opt out, such as a form that can be sent via electronic mail or a process at the licensee's web site, if the consumer agrees to the electronic delivery of information; or

(IV) Provides a toll-free telephone number that consumers may call to opt out.

C. *[Unreasonable opt out means.]* A licensee does not provide a reasonable means of opting out if *:/—*:

(I) The only means of opting out is for the consumer to write his or her own letter to exercise that opt out right; or

(II) The only means of opting out as described in any notice subsequent to the initial notice is to use a check-off box that the licensee provided with the initial notice, but did not include with the subsequent notice.

D. *[Specific opt out means.]* A licensee may require each consumer to opt out through a specific means, as long as that means is reasonable for that consumer.

3. *[Same form as initial notice permitted.]* A licensee may provide the opt out notice together with or on the same written or electronic form as the initial notice the licensee provides in accordance with subsection (2)(A).

4. *[Initial notice required when opt out notice delivered subsequent to initial notice.]* If a licensee provides the opt out notice later than required for the initial notice in accordance with subsection (2)(A), the licensee shall also include a copy of the initial notice with the opt out notice in writing or, if the consumer agrees, electronically.

5. Joint relationships.

A. If two (2) or more consumers jointly obtain an insurance product or service from a licensee, the licensee may provide a single opt out notice*/. The licensee's opt out notice shall explain/, which explains* how the licensee will treat an opt out direction by a

joint consumer (as explained in subparagraph (2)(D)5.E.).

B. Any of the joint consumers may exercise the right to opt out. The licensee may either:—

(I) Treat an opt out direction by a joint consumer as applying to all of the associated joint consumers; or

(II) Permit each joint consumer to opt out separately.

C. If a licensee permits each joint consumer to opt out separately, the licensee shall permit one (1) of the joint consumers to opt out on behalf of all of the joint consumers.

D. A licensee may not require all joint consumers to opt out before it implements any opt out direction.

E. Example. If John and Mary are both named policyholders on a homeowner's insurance policy issued by a licensee and the licensee sends policy statements to John's address, the licensee may do any of the following, but it shall explain in its opt-out notice which opt out policy the licensee will follow:

(I) Send a single opt out notice to John's address, but *[the licensee shall]* accept an opt out direction from either John or Mary.

(II) Treat an opt out direction by either John or Mary as applying to the entire policy. If the licensee does so and John opts out, the licensee may not require Mary to opt out as well before implementing John's opt out direction.

(III) Permit John and Mary to make different opt out directions. If the licensee does so:—

(a) It shall permit John and Mary to opt out for each other;

(b) If both opt out, the licensee shall permit both of them to notify it in a single response (such as on a form or through a telephone call); and

(c) If John opts out and Mary does not, the licensee may only disclose nonpublic personal financial information about Mary, but not about John, and not about John and Mary jointly.

6. *[Time to comply with opt out.]* A licensee shall comply with a consumer's opt out direction as soon as reasonably practicable after the licensee receives it.

7. *[Continuing right to opt out.]* A consumer may exercise the right to opt out at any time.

8. Duration of consumer's opt out direction.

A. A consumer's direction to opt out under this section is effective until the consumer revokes it in writing or, if the consumer agrees, electronically.

B. When a customer relationship terminates, the customer's opt out direction continues to apply to the nonpublic personal financial information that the licensee collected during or related to that relationship. If the individual subsequently establishes a new customer relationship with the licensee, the opt out direction that applied to the former relationship does not apply to the new relationship.

9. *[Delivery.]* When a licensee *[is required to]* delivers an opt out notice *[by]* pursuant to this section, the licensee shall deliver it according to subsection (2)(F).

(E) Revised Privacy Notices.

1. *[General rule.]* Except as otherwise authorized in this rule, a licensee shall not, directly or through an affiliate, disclose any nonpublic personal financial information about a consumer to a nonaffiliated third party other than as described in the initial notice that the licensee provided to that consumer under subsection (2)(A), unless:—

A. The licensee has provided to the consumer a clear and conspicuous revised notice that accurately describes its policies and practices;

B. The licensee has provided to the consumer a new opt out notice;

C. The licensee has given the consumer a reasonable opportunity, before the licensee discloses the information to the nonaffiliated third party, to opt out of the disclosure; and

D. The consumer does not opt out.

2. Examples.

A. Except as otherwise permitted by subsections (4)(A), (4)(B), and (4)(C), a licensee shall provide a revised notice before it:

(I) Discloses a new category of nonpublic personal financial information to any nonaffiliated third party;

(II) Discloses nonpublic personal financial information to a new category of nonaffiliated third party; or

(III) Discloses nonpublic personal financial information about a former customer to a nonaffiliated third party, if that former customer has not had the opportunity to exercise an opt out right regarding that disclosure.

B. A revised notice is not required if the licensee discloses nonpublic personal financial information to a new nonaffiliated third party that the licensee adequately described in its prior notice.

3. *[Delivery.]* When a licensee *[is required to]* delivers a revised privacy notice *[by]* pursuant to this section, the licensee shall deliver it according to subsection (2)(F).

(F) Delivery.

1. *[How to provide notices.]* A licensee shall provide any notices that this rule requires so that each consumer can reasonably be expected to receive actual notice in writing or, if the consumer agrees, electronically.

2. *[Examples of reasonable expectation of actual notice.]* A licensee may reasonably expect that a consumer will receive actual notice if the licensee:—

A. Hand-delivers a printed copy of the notice to the consumer;

B. Mails a printed copy of the notice to the last known address of the consumer separately, or in a policy, billing or, other written communication;

C. For a consumer who conducts transactions electronically, posts the notice on the electronic site and requires the consumer to acknowledge receipt of the notice as a necessary step to obtaining a particular insurance product or service;

D. For an isolated transaction with a consumer, such as the licensee providing an insurance quote or selling the consumer travel insurance, posts the notice and requires the consumer to acknowledge receipt of the notice as a necessary step to obtaining the particular insurance product or service.

3. *[Examples of unreasonable expectation of actual notice.]* A licensee may not, *[however,]* reasonably expect that a consumer will receive actual notice of its privacy policies and practices if it:

A. Only posts a sign in its office or generally publishes advertisements of its privacy policies and practices; or

B. Sends the notice via electronic mail to a consumer who does not obtain an insurance product or service from the licensee electronically.

4. *[Annual notices only.]* A licensee may reasonably expect that a customer will receive actual notice of the licensee's annual privacy notice if:—

A. The customer uses the licensee's web site to access insurance products and services electronically and agrees to receive notices at the web site and the licensee posts its current privacy notice continuously in a clear and conspicuous manner on the web site; or

B. The customer has requested that the licensee refrain from sending any information regarding the customer relationship, and the licensee's current privacy notice remains available to the customer upon request.

5. Oral description of notice insufficient. A licensee may not provide any notice *[required by]* pursuant to this rule solely by orally explaining the notice, either in person or over the telephone.

6. Retention or accessibility of notices for customers.

A. For customers only, a licensee shall provide the initial notice *[required by]* outlined in subparagraph (2)(A)1.A., the annual notice *[required by]* outlined in paragraph (2)(B)1., and the revised notice *[required by]* outlined in subsection (2)(E) so that the customer can retain them or obtain them later in writing or, if the customer agrees, electronically.

B. *[Examples of retention or accessibility.]* A licensee provides a privacy notice to the customer so that the customer can retain it or obtain it later if the licensee~~:/~~—

(I) Hand-delivers a printed copy of the notice to the customer;

(II) Mails a printed copy of the notice to the last known address of the customer; or

(III) Makes its current privacy notice available on a web site (or a link to another web site) for the customer who obtains an insurance product or service electronically and agrees to receive the notice at the web site.

7. *[Joint notice with other financial institutions.]* A licensee may provide a joint notice from the licensee and one (1) or more of its affiliates or other financial institutions, as identified in the notice, as long as the notice is accurate with respect to the licensee and the other institutions. A licensee also may provide a notice on behalf of another financial institution.

8. *[Joint relationships.]* If two (2) or more consumers jointly obtain an insurance product or service from a licensee, the licensee may satisfy the initial, annual, and revised notice requirements of paragraphs (2)(A)1., (2)(B)1. and (2)(E)1., respectively, by providing one notice to those consumers jointly.

(3) Limits on Disclosures of Financial Information.

(A) Limits on Disclosure of Nonpublic Personal Financial Information to Nonaffiliated Third Parties.

1. Conditions for disclosure. Except as otherwise authorized in this rule, a licensee may not, directly or through any affiliate, disclose any nonpublic personal financial information about a consumer to a nonaffiliated third party unless~~:/~~—

A. The licensee has provided to the consumer an initial notice *[as required under]* pursuant to subsection (2)(A);

B. The licensee has provided to the consumer an opt out notice *[as required in]* pursuant to subsection (2)(D);

C. The licensee has given the consumer a reasonable opportunity, before it discloses the information to the nonaffiliated third party, to opt out of the disclosure; and

D. The consumer does not opt out.

2. *[Opt out definition.]* Opt out means a direction by the consumer that the licensee not disclose nonpublic personal financial information about that consumer to a nonaffiliated third party, other than as permitted by subsections (4)(A), (4)(B), and (4)(C).

A. *[Examples of reasonable opportunity to opt out.]* A licensee provides a consumer with a reasonable opportunity to opt out if~~:/~~—

(I) *[By mail.]* The licensee mails the notices *[required]* described in paragraph (3)(A)1. to the consumer and allows the consumer to opt out by mailing a form, calling a toll-free telephone number, or any other reasonable means within thirty (30) days from the date the licensee mailed the notices.

(II) *[By electronic means.]* A customer opens an on-line account with a licensee and agrees to receive the notices *[required]* described in paragraph (3)(A)1. electronically, and the licensee allows the customer to opt out by any reasonable means within thirty (30) days after the date that the customer acknowledges receipt of the notices in conjunction with opening the account.

(III) *[Isolated transaction with consumer.]* For an isolated transaction such as providing the consumer with an insurance quote, a licensee provides the consumer with a reasonable opportunity to opt out if the licensee provides the notices *[required]* described in paragraph (3)(A)1. at the time of the transaction, and requests that the consumer decide, as a necessary part of the transaction, whether to opt out before completing the transaction.

3. Application of opt out to all consumers and all nonpublic personal financial information.

A. A licensee shall comply with this section, regardless of whether the licensee and the consumer have established a customer relationship.

B. Unless a licensee complies with this section, the licensee

may not, directly or through any affiliate, disclose any nonpublic personal financial information about a consumer that the licensee has collected, regardless of whether the licensee collected it before or after receiving the direction to opt out from the consumer.

4. *[Partial opt out.]* A licensee may allow a consumer to select certain nonpublic personal financial information or certain nonaffiliated third parties with respect to which the consumer wishes to opt out.

(B) Limits on Rediscovery and Reuse of Nonpublic Personal Financial Information.

1. Information the licensee receives under an exception. If a licensee receives nonpublic personal financial information from a nonaffiliated financial institution under an exception in subsection (4)(B) or (4)(C) of this rule, the licensee's disclosure and use of that information is limited as follows:

A. The licensee may disclose the information to the affiliates of the financial institution from which the licensee received the information;

B. The licensee may disclose the information to its affiliates, but the licensee's affiliates may, in turn, disclose and use the information only to the extent that the licensee may disclose and use the information; and

C. The licensee may disclose and use the information pursuant to an exception in subsection (4)(B) or (4)(C) of this rule, in the ordinary course of business to carry out the activity covered by the exception under which the licensee received the information.

(I) Example. If a licensee receives information from a nonaffiliated financial institution for claims settlement purposes, the licensee may disclose the information for fraud prevention, or in response to a properly authorized subpoena. The licensee may not disclose that information to a third party for marketing purposes or use that information for its own marketing purposes.

2. Information a licensee receives outside of an exception. If a licensee receives nonpublic personal financial information from a nonaffiliated financial institution other than under an exception in subsection (4)(B) or (4)(C) of this rule, the licensee may disclose the information only~~:/~~—

A. To the affiliates of the financial institution from which the licensee received the information;

B. To its affiliates, but its affiliates may, in turn, disclose the information only to the extent that the licensee may disclose the information; and

C. To any other person, if the disclosure would be lawful if made directly to that person by the financial institution from which the licensee received the information. Example: If a licensee obtains a customer list from a nonaffiliated financial institution outside of the exceptions in subsection (4)(B) or (4)(C)~~:/~~;

~~[[/]] T~~the licensee may use that list for its own purposes; and

~~[[/]] T~~the licensee may disclose that list to another nonaffiliated third party only if the financial institution from which the licensee purchased the list could have lawfully disclosed the list to that third party. That is, the licensee may disclose the list in accordance with the privacy policy of the financial institution from which the licensee received the list, as limited by the opt out direction of each consumer whose nonpublic personal financial information the licensee intends to disclose, and the licensee may disclose the list in accordance with an exception in subsections (4)(B) or (4)(C), such as to the licensee's attorneys or accountants.

3. *[Information a licensee discloses under an exception.]* If a licensee discloses nonpublic personal financial information to a nonaffiliated third party under an exception in subsections (4)(B) or (4)(C) of this rule, the third party may disclose and use that information only as follows:

A. The third party may disclose the information to the licensee's affiliates;

B. The third party may disclose the information to its affiliates, but its affiliates may, in turn, disclose and use the information only to the extent that the third party may disclose and use the information;

and

C. The third party may disclose and use the information pursuant to an exception in subsection (4)(B) or (4)(C) in the ordinary course of business to carry out the activity covered by the exception under which it received the information.

4. *[Information a licensee discloses outside of an exception.]* If a licensee discloses nonpublic personal financial information to a nonaffiliated third party other than under an exception in subsection (4)(B) or (4)(C) of this rule, the third party may disclose the information only:

A. To the licensee's affiliates;

B. To the third party's affiliates, but the third party's affiliates, in turn, may disclose the information only to the extent the third party can disclose the information; and

C. To any other person, if the disclosure would be lawful if the licensee made it directly to that person.

(C) Limits on Sharing Account Number Information for Marketing Purposes.

1. *[General prohibition on disclosure of account numbers.]* A licensee shall not, directly or through an affiliate, disclose, other than to a consumer reporting agency, a policy number or similar form of access number or access code for a consumer's policy or transaction account to any nonaffiliated third party for use in telemarketing, direct mail marketing, or other marketing through electronic mail to the consumer.

2. *[Exceptions.]* Paragraph (3)(C)1. does not apply if a licensee discloses a policy number or similar form of access number or access code:

A. To the licensee's service provider solely in order to perform marketing for the licensee's own products or services, as long as the service provider is not authorized to directly initiate charges to the account;

B. To a licensee who is a producer solely in order to perform marketing for the licensee's own products or services; or

C. To a participant in an affinity or similar program where the participants in the program are identified to the customer when the customer enters into the program.

3. Examples.

A. *[Policy number.]* A policy number, or similar form of access number or access code, does not include a number or code in an encrypted form, as long as the licensee does not provide the recipient with a means to decode the number or code.

B. *[Policy or transaction account.]* For the purposes of this section, a policy or transaction account is an account other than a deposit account or a credit card account. A policy or transaction account does not include an account to which third parties cannot initiate charges.

(4) Exceptions to Limits on Disclosures of Financial Information.

(A) Exception to Opt Out Requirements for Disclosure of Nonpublic Personal Financial Information for Service Providers and Joint Marketing.

1. General rule.

A. The opt out requirements in subsections (2)(D) and (3)(A) do not apply when a licensee provides nonpublic personal financial information to a nonaffiliated third party to perform services for the licensee or functions on the licensee's behalf, if the licensee:

(I) Provides the initial notice in accordance with subsection (2)(A); and

(II) Enters into a contractual agreement with the third party that prohibits the third party from disclosing or using the information other than to carry out the purposes for which the licensee disclosed the information, including use under an exception in subsection (4)(B) or (4)(C) in the ordinary course of business to carry out those purposes.

B. *[Example.]* If a licensee discloses nonpublic personal financial information under this section to a financial institution with which the licensee performs joint marketing, the licensee's contractual agreement with that institution meets the requirements of part

(4)(A)1.A.(II) if it prohibits the institution from disclosing or using the nonpublic personal financial information except as necessary to carry out the joint marketing or under an exception in subsection (4)(B) or (4)(C) in the ordinary course of business to carry out that joint marketing.

2. *[Service may include joint marketing.]* The services a nonaffiliated third party performs for a licensee under paragraph (4)(A)1. of this section may include marketing of the licensee's own products or services or marketing of financial products or services offered pursuant to joint agreements between the licensee and one (1) or more financial institutions.

3. *[Definition of "joint agreement."]* For purposes of this section, "joint agreement" means a written contract pursuant to which a licensee and one (1) or more financial institutions jointly offer, endorse or, sponsor a financial product or service.

(B) Exceptions to Notice and Opt Out Requirements for Disclosure of Nonpublic Personal Financial Information for Processing and Servicing Transactions.

1. *[Exceptions for processing transactions at consumer's request.]* The requirements for initial notice in subparagraph (2)(A)1.B., the opt out in subsections (2)(D) and (3)(A), and service providers and joint marketing in subsection (4)(A) do not apply if the licensee discloses nonpublic personal financial information as necessary to effect, administer, or enforce a transaction that a consumer requests or authorizes, or in connection with:/—

A. Servicing or processing an insurance product or service that a consumer requests or authorizes;

B. Maintaining or servicing the consumer's account with a licensee, or with another entity as part of a private label credit card program or other extension of credit on behalf of such entity;

C. A proposed or actual securitization, secondary market sale (including sales of servicing rights), or similar transaction related to a transaction of the consumer;

D. Reinsurance or stop loss or excess loss insurance; or

E. Soliciting insurance quotes on behalf of a consumer by an agent or a broker.

2. "Necessary to effect, administer or enforce a transaction" means that the disclosure is:/—

A. Required, or is one of the lawful or appropriate methods, to enforce the licensee's rights or the rights of other persons engaged in carrying out the financial transaction or providing the product or service; or

B. Required, or is a usual, appropriate, or acceptable method:

(I) To carry out the transaction or the product or service business of which the transaction is a part, and record, service, or maintain the consumer's account in the ordinary course of providing the insurance product or service;

(II) To administer or service benefits or claims relating to the transaction or the product or service business of which it is a part;

(III) To provide a confirmation, statement or other record of the transaction, or information on the status or value of the insurance product or service to the consumer or the consumer's agent or broker;

(IV) To accrue or recognize incentives or bonuses associated with the transaction that are provided by a licensee or any other party;

(V) To underwrite insurance at the consumer's request or for any of the following purposes as they relate to a consumer's insurance: account administration, reporting, investigating or preventing fraud or material misrepresentation, processing premium payments, processing insurance claims, administering insurance benefits (including utilization review activities), participating in research projects or as otherwise required or specifically permitted by federal or state law; or

(VI) In connection with:/—

(a) The authorization, settlement, billing, processing, clearing, transferring, reconciling or collection of amounts charged, debited, or otherwise paid using a debit, credit, or other payment

card, check or account number, or by other payment means;

(b) The transfer of receivables, accounts, or interests therein; or

(c) The audit of debit, credit, or other payment information.

(C) Other Exceptions to Notice and Opt Out Requirements for Disclosure of Nonpublic Personal Financial Information.

1. *[Exceptions to opt out requirements.]* The requirements for initial notice in subparagraph (2)(A)1.B., the opt out in subsections (2)(D) and (3)(A), and service providers and joint marketing in subsection (4)(A) do not apply when a licensee discloses nonpublic personal financial information:/—

A. With the consent or at the direction of the consumer, provided that the consumer has not revoked the consent or direction;

B. To protect the confidentiality or security of a licensee's records pertaining to the consumer, service, product, or transaction;

C. To protect against or prevent actual or potential fraud or unauthorized transactions;

D. For required institutional risk control or for resolving consumer disputes or inquiries;

E. To persons holding a legal or beneficial interest relating to the consumer;

F. To persons acting in a fiduciary or representative capacity on behalf of the consumer;

G. To provide information to insurance rate advisory organizations, guaranty funds or agencies, agencies that are rating a licensee, persons that are assessing the licensee's compliance with industry standards, and the licensee's attorneys, accountants, and auditors;

H. To the extent specifically permitted or required under other provisions of law and in accordance with the federal Right to Financial Privacy Act of 1978 (12 U.S.C. 3401 *et seq.*), to law enforcement agencies (including the Federal Reserve Board, Office of the Comptroller of the Currency, Federal Deposit Insurance Corporation, Office of Thrift Supervision, National Credit Union Administration, the Securities and Exchange Commission, the Secretary of the Treasury, with respect to 31 U.S.C. Chapter 53, Subchapter II (Records and Reports on Monetary Instruments and Transactions) and 12 U.S.C. Chapter 21 (Financial Recordkeeping), a state insurance authority, and the Federal Trade Commission), self-regulatory organizations or for an investigation on a matter related to public safety;

I. To a consumer reporting agency in accordance with the federal Fair Credit Reporting Act (15 U.S.C. 1681 *et seq.*);

J. From a consumer report reported by a consumer reporting agency;

K. In connection with a proposed or actual sale, merger, transfer, or exchange of all or a portion of a business or operating unit if the disclosure of nonpublic personal financial information concerns solely consumers of the business or unit;

L. To comply with federal, state, or local laws, rules, and other applicable legal requirements;

M. To comply with a properly authorized civil, criminal, or regulatory investigation, or subpoena or summons by federal, state, or local authorities;

N. To respond to judicial process or government regulatory authorities having jurisdiction over a licensee for examination, compliance, or other purposes as authorized by law; or

O. For purposes related to the replacement of a group benefit plan, a group health plan, a group welfare plan, or a workers' compensation plan.

2. *[Example of revocation of consent.]* A consumer may revoke consent by subsequently exercising the right to opt out of future disclosures of nonpublic personal information as permitted under paragraph (2)(D)7.

(5) Additional Provisions.

(A) *[Protection of Fair Credit Reporting Act.]* Nothing in this rule *[shall]* **may** be construed to modify, limit, or supersede the

operation of the federal Fair Credit Reporting Act (15 U.S.C. 1681 *et seq.*), and no inference *[shall]* **may** be drawn on the basis of the provisions of this rule regarding whether information is transaction or experience information under section 603 of that Act.

(B) *[Nondiscrimination.]* A licensee shall not unfairly discriminate against any consumer or customer because that consumer or customer has opted out from the disclosure of his or her nonpublic personal financial information pursuant to the provisions of this rule. Nothing in this subsection *[shall]* **may** be construed to prohibit the use of usual, appropriate, or acceptable methods of insurance underwriting.

(C) *[Severability.]* If any section or portion of a section of this rule or its applicability to any person or circumstance is held invalid by a court, the remainder of the rule or the applicability of the provision to other persons or circumstances shall not be affected.

(D) Effective Date.

[1. Effective date. This rule becomes effective thirty (30) days after publication in the Code of State Regulations.] After the effective date of this rule, no licensee may disclose nonpublic personal financial information to nonaffiliated third parties without first complying with the provisions of section (3) of this rule, including subparagraph (3)(A)1.A. *[For consumers who became customers before July 1, 2001, the initial notices required by section (2)(A) must be given by June 30, 2002.]*

[2. Two (2)-year grandfathering of service agreements. Until July 1, 2002, a contract that a licensee has entered into with a nonaffiliated third party to perform services for the licensee or functions on the licensee's behalf satisfies the provisions of part (4)(A)1.A.(II) of this rule, even if the contract does not include a requirement that the third party maintain the confidentiality of nonpublic personal information, as long as the licensee entered into the agreement on or before July 1, 2000.]

APPENDIX A—SAMPLE CLAUSES

Licensees, including a group of financial holding company affiliates that use a common privacy notice, may use the following sample clauses, if the clause is accurate for each institution that uses the notice. (Note that disclosure of certain information, such as assets, income and information from a consumer reporting agency, may give rise to obligations under the federal Fair Credit Reporting Act, such as a requirement to permit a consumer to opt out of disclosures to affiliates or designation as a consumer reporting agency if disclosures are made to nonaffiliated third parties.)

A-1—Categories of information a licensee collects (all institutions)

A licensee may use this clause, as applicable, to meet the requirement of subparagraph (2)(C)1.A. to describe the categories of nonpublic personal information the licensee collects.

Sample Clause A-1:

We collect nonpublic personal information about you from the following sources:

- *Information we receive from you on applications or other forms;*
- *Information about your transactions with us, our affiliates or others; and*
- *Information we receive from a consumer reporting agency.*

A-2—Categories of information a licensee discloses (institutions that disclose outside of the exceptions)

A licensee may use one of these clauses, as applicable, to meet the requirement of subparagraph (2)(C)1.B. to describe the categories of nonpublic personal information the licensee discloses. The licensee may use these clauses if it discloses

nonpublic personal information other than as permitted by the exceptions in subsections (4)(A), (4)(B), and (4)(C).

Sample Clause A-2, Alternative 1:

We may disclose the following kinds of nonpublic personal information about you:

- Information we receive from you on applications or other forms, such as [provide illustrative examples, such as “your name, address, social security number, assets, income, and beneficiaries”];
- Information about your transactions with us, our affiliates or others, such as [provide illustrative examples, such as “your policy coverage, premiums, and payment history”]; and
- Information we receive from a consumer reporting agency, such as [provide illustrative examples, such as “your creditworthiness and credit history”].

Sample Clause A-2, Alternative 2:

We may disclose all of the information that we collect, as described [describe location in the notice, such as “above” or “below”].

A-3—Categories of information a licensee discloses and parties to whom the licensee discloses (institutions that do not disclose outside of the exceptions)

A licensee may use this clause, as applicable, to meet the requirements of subparagraphs (2)(C)1.B., (2)(C)1.C., and (2)(C)1.D. to describe the categories of nonpublic personal information about customers and former customers that the licensee discloses and the categories of affiliates and nonaffiliated third parties to whom the licensee discloses. A licensee may use this clause if the licensee does not disclose nonpublic personal information to any party, other than as permitted by the exceptions in subsections (4)(B) and (4)(C).

Sample Clause A-3:

We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted by law.

A-4—Categories of parties to whom a licensee discloses (institutions that disclose outside of the exceptions)

A licensee may use this clause, as applicable, to meet the requirement of subparagraph (2)(C)1.C. to describe the categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal information. This clause may be used if the licensee discloses nonpublic personal information other than as permitted by the exceptions in subsections (4)(A), (4)(B), and (4)(C), as well as when permitted by the exceptions in subsections (4)(B) and (4)(C).

Sample Clause A-4:

We may disclose nonpublic personal information about you to the following types of third parties:

- Financial service providers, such as [provide illustrative examples, such as “life insurers, automobile insurers, mortgage bankers, securities broker-dealers, and insurance agents”];
- Non-financial companies, such as [provide illustrative examples, such as “retailers, direct marketers, airlines, and publishers”]; and
- Others, such as [provide illustrative examples, such as “non-profit organizations”].

We may also disclose nonpublic personal information about you to nonaffiliated third parties as permitted by law.

A-5—Service provider/joint marketing exception

A licensee may use one of these clauses, as applicable, to meet the requirements of subparagraph (2)(C)1.E. related to the exception for service providers and joint marketers in subsection (4)(A). If a licensee discloses nonpublic personal information under this exception, the licensee shall describe

the categories of nonpublic personal information the licensee discloses and the categories of third parties with which the licensee has contracted.

Sample Clause A-5, Alternative 1:

We may disclose the following information to companies that perform marketing services on our behalf or to other financial institutions with which we have joint marketing agreements:

- Information we receive from you on applications or other forms, such as [provide illustrative examples, such as “your name, address, social security number, assets, income, and beneficiaries”];
- Information about your transactions with us, our affiliates or others, such as [provide illustrative examples, such as “your policy coverage, premium, and payment history”]; and
- Information we receive from a consumer reporting agency, such as [provide illustrative examples, such as “your creditworthiness and credit history”].

Sample Clause A-5, Alternative 2:

We may disclose all of the information we collect, as described [describe location in the notice, such as “above” or “below”] to companies that perform marketing services on our behalf or to other financial institutions with whom we have joint marketing agreements.

A-6—Explanation of opt out right (institutions that disclose outside of the exceptions)

A licensee may use this clause, as applicable, to meet the requirement of subparagraph (2)(C)1.F. to provide an explanation of the consumer’s right to opt out of the disclosure of nonpublic personal information to nonaffiliated third parties, including the method(s) by which the consumer may exercise that right. The licensee may use this clause if the licensee discloses nonpublic personal information other than as permitted by the exceptions in subsections (4)(A), (4)(B), and (4)(C).

Sample Clause A-6:

If you prefer that we not disclose nonpublic personal information about you to nonaffiliated third parties, you may opt out of those disclosures, that is, you may direct us not to make those disclosures (other than disclosures permitted by law). If you wish to opt out of disclosures to nonaffiliated third parties, you may [describe a reasonable means of opting out, such as “call the following toll-free number: (insert number)”].

A-7—Confidentiality and security (all institutions)

A licensee may use this clause, as applicable, to meet the requirement of subparagraph (2)(C)1.H. to describe its policies and practices with respect to protecting the confidentiality and security of nonpublic personal information.

Sample Clause A-7:

We restrict access to nonpublic personal information about you to [provide an appropriate description, such as “those employees who need to know that information to provide products or services to you”]. We maintain physical, electronic, and procedural safeguards that comply with federal rules to guard your nonpublic personal information.]

AUTHORITY: sections 362.422[, RSMo Supp. 2007] and [section] 374.045, RSMo [2000] 2016. Emergency rule filed June 21, 2001, effective July 1, 2001, expired Dec. 28, 2001. Original rule filed Aug. 31, 2001, effective March 30, 2002. Amended: Filed Nov. 1, 2007, effective July 30, 2008. Amended: Filed Oct. 30, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Amy V. Hoyt, PO Box 690, Jefferson City, MO. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register.

**Title 20—DEPARTMENT OF INSURANCE,
FINANCIAL INSTITUTIONS AND PROFESSIONAL
REGISTRATION**

**Division 100—Insurer Conduct
Chapter 9—Filing Requirements**

PROPOSED AMENDMENT

20 CSR 100-9.100 Requirements for the Filing of Papers, Documents, or Reports with the Insurance Market Regulation Division. The director is amending sections (1), (2), (3), and the existing section (4), and adding a new subsection.

PURPOSE: The purpose of this amendment is to consolidate all rules related to requirements for filings made with the Insurance Market Regulation Division, and to amend the filing fee amounts to comply with section 374.230, SS SB 982, 99th Gen. Assemb. (2018).

(1) Scope. This rule is applicable to any company filing papers, documents, or reports, which are *[required to be]* filed under Missouri law, with the Insurance Market Regulation Division, as permitted by law.

(2) Definitions. As used in 20 CSR 100-9.100 the following terms mean:

(G) Document—any form, rate, **report**, or rule that is legally required to be delivered either to the division, or to the department or director through the division, and any other form, rate, **report**, or rule intended to be delivered either to the division, or to the department, or director through the division. Documents do not include any form, rate, **report**, or rule that is legally required to be delivered either to the market conduct section or to the department or director through the market conduct section;

(H) Filing Submission—one (1) or more related documents, which have been delivered through SERFF under a single SERFF tracking number *[by a company]*, that has not yet been treated as filed, received, or deficient;

(N) Report—any report or **certification** that is legally required to be delivered either to the division, or to the department, or director through the division, and any other report intended to be delivered either to the division, or to the department, or director through the division. A report does not include: any statistical data submitted to the division pursuant to a data call under section 374.190, RSMo, or any report that is legally required to be delivered either to the market conduct section or to the department or director through the market conduct section;

(3) Filing Requirements.

(A) All documents *[must be]* submitted.

(D) Any document that supersedes another document within a filing submission will be treated as a new filing submission. *[The new filing submission must meet all requirements within this rule except]* All provisions in this rule apply except that no additional fee will be charged for any document that supersedes another document within a filing submission.

(4) Filing Requirements for Life Insurance. Life insurance forms

must be submitted separately from health insurance forms, pursuant to section 376.010. However, this restriction does not apply where the combination of coverage is inherent to the plan design of group coverage.

[(4)](5) Filing Fees.

(A) *[Any filing submission, e]* Except as provided below or otherwise provided by statute, a filing submission must include a filing fee of one hundred fifty dollars (\$150) per submission per company. If any company which is a member of a group of related companies makes a filing on behalf of any or all of the companies in that group, the filing is considered a separate filing for each of the companies on behalf of which the filing was made, and each of those companies will pay a filing fee.

1. With respect to a filing submission for a company not formed under Chapter 380 or a discount medical plan formed under Chapter 376, the filing fee is one hundred fifty dollars (\$150) per form submitted to the division.

2. With respect to a farm mutual, formed under Chapter 380, RSMo, no filing fee *[is required for any such filing submission]* will be charged.

[2.]3. With respect to any extended farm mutual, formed under Chapter 380, RSMo, *[any such filing submission must include a]* the filing fee *[of]* is ten dollars (\$10) per form submitted to the division.

[3.]4. With respect to any discount medical plan, formed under Chapter 376, RSMo, *[any such filing submission must include a]* the filing fee *[of]* is twenty-five dollars (\$25) per form submitted to the division.

(B) *[Any filing submission, paper, or report]* All filing fees for any filing submission must be *[paid for]* remitted through the SERFF Electronic Funds Transfer (EFT) system.

AUTHORITY: sections 354.085, 354.120, 354.485, 354.723, 374.045, 374.056, 375.013, 376.405, 376.675, 376.1025, 376.1095, 376.1399, 379.351, [and] 380.561, [RSMo 2000, and sections 354.085, 354.485, 374.045, 374.056, 376.405, 376.777, 376.1399,] 381.042, and 383.035, RSMo [Supp. 2013] 2016. Original rule filed July 15, 2015, effective Jan. 30, 2016. Amended: Filed Oct. 30, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Amy V. Hoyt, PO Box 690, Jefferson City, MO. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register.

**Title 20—DEPARTMENT OF INSURANCE,
FINANCIAL INSTITUTIONS AND PROFESSIONAL
REGISTRATION**

**Division 200—Insurance Solvency and Company
Regulation
Chapter 1—Financial Solvency and Accounting Standards**

PROPOSED AMENDMENT

20 CSR 200-1.005 Materials *[Incorporated by Reference]* to be Utilized by the Director. The director is amending sections (1) and

(2), deleting section (3), amending the rule title, amending the purpose statement, and removing the publisher's note.

PURPOSE: *This amendment maintains clear guidance on publications used by the department while removing references to specific editions of the publications in the rule, thereby ensuring that the most recent publication will be in effect.*

PURPOSE: *The purpose[s] of this rule [are to prescribe forms and procedures to be followed in proceedings before the Department of Insurance, Financial Institutions and Professional Registration and] is to effectuate or aid in the interpretation of any law of this state pertaining to the business of insurance, by providing specific information regarding certain publications [incorporated by reference] utilized by the director in the furtherance of his or her statutory duties and referenced in rules in this division.*

(1) The director [adopts and incorporates by reference in rules of this division] **may utilize** the following [rules, regulations, standards, and guidelines] **publications** of the National Association of Insurance Commissioners (NAIC) [without publishing the materials in full] **in the furtherance of his or her statutory duties:**

(A) *Accounting Practices and Procedures Manual [(March 2011)]*, also referred to as the Accounting Practices and Procedures Manual for Fire and Casualty Insurance Companies and as the Accounting Practices and Procedures Manual for Life and Accident and Health Insurance Companies;

(B) *Annual Statement Instructions [(August 2010)]*;

(C) *Purposes and Procedures Manual of the NAIC [Securities Valuation] Investment Analysis Office [(July 1, 2010)]*, also referred to as the Valuation of Securities; [and]

(D) *Financial Condition Examiner[']s Handbook [(2010)]*, also referred to as the Examiner's Handbook; **and**

(E) *Financial Analysis Handbook.*

(2) The above referenced [rules, regulations, standards, or guidelines do not include any later amendments or additions] **publications are updated annually or biannually by the NAIC. The director will maintain a list of the above referenced publications on the department's website, with the editions currently in use clearly specified. References in rules of this department to the above referenced publications refer to the editions listed on the department's website, unless otherwise specified.**

[[3) *The publisher's name and address is the National Association of Insurance Commissioners, Central Office, 2301 McGee Street, Suite 800, Kansas City, MO 64108-2662.*]

AUTHORITY: *section 374.045, RSMo [Supp. 2010] 2016. Original rule filed July 15, 2009, effective Feb. 28, 2010. Amended: Filed Feb. 14, 2011, effective Aug. 30, 2011. Amended: Filed Oct. 30, 2018.*

PUBLIC COST: *This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

PRIVATE COST: *This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

NOTICE TO SUBMIT COMMENTS: *Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Meaghan Forck, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION

Division 200—Insurance Solvency and Company Regulation

Chapter 1—Financial Solvency and Accounting Standards

PROPOSED RESCISSION

20 CSR 200-1.010 Financial Condition of Insurance Companies. This rule enumerated conditions which may have indicated that an insurer was in a financial condition which would require further scrutiny in order to protect its policyholders, claimants, creditors, shareholders, and the public.

PURPOSE: *This rule is being rescinded because it was superseded by the enactment of section 375.539, RSMo in 2010.*

AUTHORITY: *sections 374.040, 374.045 and 374.190, RSMo 2000 and Chapter 375, RSMo 2000 and Supp. 2001. This rule was previously filed as 4 CSR 190-11.005. Original rule filed Aug. 1, 1990, effective Dec. 31, 1990. Amended: Filed July 2, 1991, effective Dec. 9, 1991. Amended: Filed April 29, 1992, effective Dec. 3, 1992. Amended: Filed July 12, 2002, effective Jan. 30, 2003. Rescinded: Filed Oct. 30, 2018.*

PUBLIC COST: *This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

PRIVATE COST: *This proposed rescission will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

NOTICE TO SUBMIT COMMENTS: *Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Meaghan Forck, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION

Division 200—Insurance Solvency and Company Regulation

Chapter 1—Financial Solvency and Accounting Standards

PROPOSED AMENDMENT

20 CSR 200-1.020 Accounting Standards and Principles. The director is amending sections (1)–(3) and amending the purpose statement.

PURPOSE: *This amendment updates the references within the rule to reflect changes in Missouri statute and regulation.*

PURPOSE: *This rule effectuates or aids in the interpretation of sections [375.560 and] 354.470, 375.537, 375.539, 375.881, 375.1160, 375.1165, and 375.1175, RSMo, and in the administration of sections 354.080 and 354.355, RSMo.*

(1) Each insurance company shall make and file statements of its assets, liabilities, capital and surplus, income and expenses, including all schedules and exhibits used in connection with such statements, which statements the director may use to determine [whether the capital stock or guarantee fund of an insurance company is impaired under section 375.560.1(1), RSMo,

whether an insurance company is insolvent under section 375.560.1(2) or 375.881.1(1), RSMo, whether an insurance company is in a financial condition that its further transaction of business would be hazardous under section 375.881.1(3) or 375.1165(1), RSMo and whether an insurance company fails to comply with the requirements for admission under section 375.881.1(2), RSMo] any of the following according to the applicable accounting guidance, standards, and principles approved by the National Association of Insurance Commissioners (NAIC), published in the *Accounting Practices and Procedures Manual*, *Annual Statement Instructions*, *Valuation of Securities [and]*, *Examiner's Handbook*, and *Financial Analysis Handbook*, except where the applicable provisions of Chapters 374–385, RSMo or other specific rules expressly provide otherwise[.];

(A) Whether an insurance company is impaired under section 375.537, RSMo;

(B) Whether any standards are implicated under section 375.539.2, RSMo;

(C) Whether an insurance company is insolvent under section 375.881(1) or 375.1175.1(2), RSMo;

(D) Whether an insurance company fails to comply with the requirements for admission under section 375.881(2), RSMo;

(E) Whether an insurance company is in such a financial condition that its further transaction of business in this state would be hazardous to policyholders and creditors in this state and to the public under section 375.881(3), RSMo;

(F) Whether an insurance company's condition renders the continuance of its business hazardous to the public or to its insureds under section 375.1160.2(1)(a), RSMo;

(G) Whether an insurance company is in such condition that the further transaction of business would be hazardous financially to its policyholders, creditors, or the public under section 375.1165(1), RSMo; and

(H) Whether an insurance company is found to be in such condition that the further transaction of business would be hazardous, financially or otherwise, to its policyholders, its creditors or the public under section 375.1175.1(3), RSMo.

(2) Each health services corporation shall make and file statements of its assets, liabilities, capital and surplus, income and expenses, including all schedules and exhibits used in connection with such statements, which statements the director may use to determine [whether a health services corporation is maintaining the reserves required by section 354.080, RSMo and whether a health services corporation is in a condition that its further transaction of business will be hazardous under section 354.355(3), RSMo] any of the following according to the applicable accounting guidance, standards [or], and principles approved by the NAIC, [or both, as] published in the *Accounting Practices and Procedures Manual*, *Annual Statement Instructions*, *Valuation of Securities [and]*, *Examiner's Handbook*, and *Financial Analysis Handbook*, except where the applicable provisions of [sections 354.010–354.380] Chapters 354 and 374–385, RSMo or other specific rules expressly provide otherwise[.];

(A) Whether a health services corporation is maintaining reserves in accordance with section 354.080, RSMo;

(B) Whether a health services corporation is in such condition that its further transaction of business will be hazardous to its policyholders or to its creditors or to the public under section 354.355(3), RSMo;

(C) Whether a health services corporation is impaired under section 375.537, RSMo;

(D) Whether any standards are implicated under section 375.539.2, RSMo;

(E) Whether a health services corporation's condition renders the continuance of its business hazardous to the public or to its insureds under section 375.1160.2(1)(a), RSMo;

(F) Whether a health services corporation is in such condition that the further transaction of business would be hazardous

financially to its policyholders, creditors, or the public under section 375.1165(1), RSMo;

(G) Whether a health services corporation is insolvent under section 375.1175.1(2), RSMo; and

(H) Whether a health services corporation is found to be in such condition that the further transaction of business would be hazardous, financially or otherwise, to its policyholders, its creditors, or the public under section 375.1175.1(3), RSMo.

(3) Each health maintenance organization shall make and file statements of its assets, liabilities, capital and surplus, income and expenses, including all schedules and exhibits used in connection with such statements, which statements the director may use to determine [whether a health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees under section 354.470.1(4), RSMo, whether the continued operation of a health maintenance organization would be hazardous to its enrollees under section 354.470.1(8), RSMo, whether a health maintenance organization is insolvent under section 375.1175(2), RSMo, and whether a health maintenance organization is in a financial condition that its further transaction of business would be hazardous under section 375.1165(1), RSMo,] any of the following according to the applicable accounting guidance, standards, and principles approved by the [National Association of Insurance Commissioners (NAIC)], published in the *Accounting Practices and Procedures Manual*, *Annual Statement Instructions*, *Valuation of Securities [and]*, *Examiner's Handbook*, and *Financial Analysis Handbook*, except where the applicable provisions of Chapters 354 and 374–385, RSMo or other specific rules expressly provide otherwise[.];

(A) Whether a health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees under section 354.470.1(4), RSMo;

(B) Whether the continued operation of a health maintenance organization would be hazardous to its enrollees under section 354.470.1(8), RSMo;

(C) Whether a health maintenance organization is impaired under section 375.537, RSMo;

(D) Whether any standards are implicated under section 375.539.2, RSMo;

(E) Whether a health maintenance organization's condition renders the continuance of its business hazardous to the public or to its insureds under section 375.1160.2(1)(a), RSMo;

(F) Whether a health maintenance organization is in such condition that the further transaction of business would be hazardous financially to its policyholders, creditors, or the public under section 375.1165(1), RSMo;

(G) Whether a health maintenance organization is insolvent under section 375.1175.1(2), RSMo; and

(H) Whether a health maintenance organization is found to be in such condition that the further transaction of business would be hazardous, financially or otherwise, to its policyholders, its creditors, or the public under section 375.1175.1(3), RSMo.

AUTHORITY: sections 354.120, 354.485, and 374.045, RSMo [2000] 2016. This rule was previously filed as 4 CSR 190-II.230. Original rule filed Feb. 3, 1989, effective May 1, 1989. Amended: Filed Aug. 25, 1989, effective Jan. 1, 1990. Amended: Filed Dec. 14, 2000, effective July 30, 2001. Amended: Filed Dec. 4, 2001, effective June 30, 2002. Amended: Filed Oct. 30, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private enti-

ties more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Meaghan Forck, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 20—DEPARTMENT OF INSURANCE,
FINANCIAL INSTITUTIONS AND PROFESSIONAL
REGISTRATION
Division 200—Insurance Solvency and Company
Regulation
Chapter 1—Financial Solvency and Accounting Standards
PROPOSED AMENDMENT**

20 CSR 200-1.025 Valuation of Invested Assets. The director is amending section (2) and amending the purpose statement.

PURPOSE: This amendment updates a statutory reference and simplifies a reference to publications of the National Association of Insurance Commissioners.

PURPOSE: This rule effectuates or aids in the interpretation of sections [376.300–376.320] 376.291–376.307 and 379.080, RSMo.

(2) Other Invested Assets. Invested assets, other than securities, must be valued in accordance with the procedures [promulgated by the NAIC's Financial Condition (EX4) Subcommittee as] published in [its] the NAIC Accounting Practices and Procedures Manual, Annual Statement Instructions [and] and Examiner's Handbook.

AUTHORITY: section 374.045, RSMo [2000] 2016. Original rule filed July 2, 1991, effective Dec. 9, 1991. Amended: Filed Aug. 29, 2003, effective Feb. 29, 2004. Amended: Filed Oct. 30, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Meaghan Forck, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 20—DEPARTMENT OF INSURANCE,
FINANCIAL INSTITUTIONS AND PROFESSIONAL
REGISTRATION
Division 200—Insurance Solvency and Company
Regulation
Chapter 1—Financial Solvency and Accounting Standards
PROPOSED RESCISSION**

20 CSR 200-1.039 Supplemental Filing Requirements for Material Transactions. This rule aided in the interpretation of sections 354.105, 354.190, 354.435, 354.465, 354.717, 354.720,

374.190, 375.041, 375.400, 376.350, 377.100, 377.380, 378.626, 379.105, 381.241, 383.030 and 384.021, RSMo, and required domestic insurance companies to disclose material transactions as addenda to the annual and quarterly financial statement filings in order to protect policyholders, claimants, creditors, shareholders, and the public.

PURPOSE: This rule is being rescinded because it exceeds the department's statutory authority with respect to multiple statutes cited in its purpose statement, and because it is not currently enforced.

AUTHORITY: sections 354.120, 354.485, 354.723, 374.045, 375.013 and 381.231, RSMo 1994. Original rule filed Aug. 1, 1995, effective March 30, 1996. Rescinded: Filed Oct. 30, 2018.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Meaghan Forck, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 20—DEPARTMENT OF INSURANCE,
FINANCIAL INSTITUTIONS AND PROFESSIONAL
REGISTRATION
Division 200—Insurance Solvency and Company
Regulation
Chapter 1—Financial Solvency and Accounting Standards
PROPOSED AMENDMENT**

20 CSR 200-1.040 Financial Standards for Health Maintenance Organizations. The director is amending sections (1)–(5) and adding a new section (6).

PURPOSE: This amendment modernizes the rule and removes outdated and unnecessary provisions.

(1) A health maintenance organization (HMO) must maintain a capital account [as required by] pursuant to section 354.410.6f., RSMo. The capital account is the equivalent of net worth and shall be equal to the assets of the HMO less its liabilities, which is also the equivalent of “net of any accrued liabilities” as used in section 354.410.6f., RSMo. Assets and liabilities will be admitted and determined under the provisions of this rule.

(2) Assets of an HMO will be admitted and included in determining the financial condition of the HMO only if included within one (1) or more of the following list of admissible assets:

(A) Investable funds under section 354.450, RSMo are as follows:
1. Any asset or investment described in and limited by sections [375.1070–375.1075, RSMo, and 376.300, 376.305 and 376.307] 376.291–376.307, RSMo; and

2. Any asset or investment described in and limited by section 354.415.1(1), RSMo. [Under section 354.415.2, RSMo, the HMO must file notice and adequate supporting information with the director for any asset or investment in excess of five hundred thousand dollars (\$500,000). If the director

does not disapprove the notice within sixty (60) days of the date of filing, the notice shall be deemed approved] **The requirements of section 354.415.2, RSMo apply as detailed in the statute; and**

(B) Other assets as follows:

1. Reinsurance recoverables pursuant to section 375.246, RSMo;
2. Data processing system pursuant to section 375.325, RSMo;
3. Premium receivable from any agency of this state, of any political subdivision of this state or of the United States;
4. Accrued interest receivable, if according to *[generally accepted standards of accounting]* **statements of statutory accounting principles** for HMOs such interest is probably collectible;
5. Inventory of medical, pharmaceutical and optical supplies, furniture, equipment and fixtures, but only if according to *[generally accepted standards of accounting]* **statements of statutory accounting principles** for HMOs such supplies, furniture, equipment and fixtures are used by the HMO in connection with the direct provision of health care services;
6. Funds paid by the HMO into escrow for the purpose of purchasing or building offices or medical facilities but only if according to *[generally accepted standards of accounting]* **statements of statutory accounting principles** for HMOs such offices or facilities are for use by the HMO in connection with the direct provision of health care services;
7. Goodwill and other intangible assets. Any goodwill or intangible asset must be amortized on a straight-line basis over a period of five (5) years or less. Any goodwill or intangible asset accrued after September 1, 1989 will be admissible only with the prior consent of the director;
8. Amounts receivable from HMOs, health service corporations, insurance companies, self-insurance plans, and third-party tortfeasors on account of coordination of benefits or subrogation, limited to the less of the actual amounts receivable or the amounts received during the prior year;
9. Any other asset expressly approved in writing by the director.

(3) No asset shall be admissible except as stated in section (2) **and in accordance with the statements of statutory accounting principles.** *[The following is a non-exclusive list of nonadmitted assets and no item listed may be admitted under section 376.307, RSMo:]*

[(A) Premiums receivable net of bad debt allowance when the receivable is greater than ninety (90) days past due, except as allowed in paragraph (2)(B)3.;

(B) Prepaid expenses, except as allowed in paragraph (2)(B)6.;

(C) Security deposits;

(D) Automobiles;

(E) Office furniture and equipment in excess of fifty percent (50%) of its depreciated value;

(F) Computer software;

(G) Letters of credit, except to secure reinsurance credit as outlined in section 375.246, RSMo, pledges to purchase stock or other guarantees by outside organizations;

(H) Capital leases; and

(I) Any asset expressly disapproved in writing by the director.]

(4) Liabilities shall be determined *[by the instructions to the National Association of Insurance Commissioners (NAIC) blank annual statement form for HMOs except the following need not be reflected as liabilities:]* **in accordance with the statements of statutory accounting principles.**

[(A) Capital leases; and

(B) Any debt subordinated and approved under 20 CSR 200-1.070.]

(5) In determining whether an HMO is financially responsible and

may reasonably be expected to meet its obligations to enrollees and prospective enrollees under sections 354.410.1(3) and 354.470.1(4), RSMo and whether the continued operation of the HMO would be hazardous either to the enrollees or to the people of this state under section 354.480, RSMo, the director *[requires compliance with the following minimum standards:]* **will consider compliance with the standards of sections 354.410, 375.539, and 375.1250-375.1275, RSMo.**

[(A) A new HMO forming initially, and for its first full calendar year of operation, must have net worth of at least ten percent (10%) of the yearly average of the three (3)-year annual premium projected in its applications for a certificate of authority, or three hundred thousand dollars (\$300,000) if an individual practice association, or one hundred fifty thousand dollars (\$150,000) if a medical group/staff, whichever is greater. After an HMO has been in business from January 1 through December 31 of a year, that is, one (1) full calendar year, it shall be treated as an existing HMO;

(B) An existing HMO must maintain a net worth of at least two percent (2%) of annual premium as shown in the HMO's most recently filed annual statement, three hundred thousand dollars (\$300,000) for an individual practice association, or one hundred fifty thousand dollars (\$150,000) for a medical group/staff model, whichever is greater. The two percent (2%) of annual premium previously mentioned shall be phased in as follows:

1. Two-thirds of one percent (2/3 of 1%) of annual premium as of December 31, 1989;

2. One and one-third percent (1 1/3%) of annual premium as of December 31, 1990; and

3. Two percent (2%) of annual premium as of December 3, 1991 and after that date; and]

[(C)](6) On any policy of insolvency insurance, the named insured must include the director of the [Missouri Department of Insurance] department and his/her successor(s) in office.

AUTHORITY: section 354.485, RSMo [2000] 2016. This rule was previously filed as 4 CSR 190-II.125. Original rule filed April 19, 1989, effective Sept. 1, 1989. Amended: Filed Sept. 15, 1992, effective June 7, 1993. Amended: Filed Nov. 23, 1998, effective July 30, 1999. Amended: Filed Dec. 14, 2000, effective July 30, 2001. Amended: Filed Oct. 30, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Meaghan Forck, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 20—DEPARTMENT OF INSURANCE,
FINANCIAL INSTITUTIONS AND PROFESSIONAL
REGISTRATION**

**Division 200—Insurance Solvency and Company
Regulation**

Chapter 1—Financial Solvency and Accounting Standards

PROPOSED AMENDMENT

20 CSR 200-1.050 Financial Standards for Prepaid Dental Plans.

The director is amending sections (1)–(4) and deleting the editor's note.

PURPOSE: *This amendment modernizes the rule and removes outdated and unnecessary provisions.*

[Editor's Note: *The secretary of state has determined that the publication of this rule in its entirety would be unduly cumbersome or expensive. The entire text of the material referenced has been filed with the secretary of state. This material may be found at the Office of the Secretary of State or at the headquarters of the agency and is available to any interested person at a cost established by state law.]*

(1) Assets of a prepaid dental plan will be admitted and included in determining the financial condition of the prepaid dental plan only if included within one (1) or more of the following list of admissible assets:

(A) Investable funds invested as follows *[shall be deemed admissible assets]*:

1. Any asset or investment described in and limited by sections *[376.300, 376.305 and 376.307]* **376.291–376.307**, RSMo; and

2. Any asset or investment representing the purchase, lease, construction, renovation, operation or maintenance of facilities from which dental benefits under the plan will be performed or property as may reasonably be *[required]* **needed** for the principal office of the prepaid dental plan or for other purposes as may be necessary in the transaction of the business of the plan; and

(B) Other assets *[shall be determined admissible assets,]* as follows:

1. Reinsurance recoverables;

2. Data processing system;

3. Premium receivable from any agency of this state, of any political subdivision of this state or of the United States;

4. Accrued interest receivable, if according to *[generally accepted standards of accounting]* **statements of statutory accounting principles** for prepaid dental plans such interest is probably collectable;

5. Inventory of dental supplies, but only if according to *[generally accepted standards of accounting]* **statements of statutory accounting principles** for prepaid dental plans such supplies are used by the prepaid dental plan in connection with the direct provision of dental services;

6. Funds paid by the prepaid dental plan into escrow for the purpose of purchasing or building offices or facilities from which dental benefits under the plan will be performed, but only if according to *[generally accepted standards of accounting]* **statements of statutory accounting principles** for prepaid dental plans such offices or facilities are for use by the prepaid dental plan in connection with the direct provision of health care services;

7. Goodwill and other intangible assets. Any goodwill or intangible asset must be amortized on a straight-line basis over a period of five (5) years or less. Any goodwill or intangible asset accrued after April 1, 1990 will be admissible only with the prior consent of the director;

8. Amounts receivable on account of coordination of benefits or subrogation, limited to the actual amounts receivable or the amounts received during the prior year, whichever is less;

9. Any other asset expressly approved in writing by the director.

(2) No asset shall be admissible except as stated in section (1) **and in accordance with the statements of statutory accounting principles.** *[The following list is a nonexclusive list of nonadmitted assets and no item listed may be admitted in determining the financial condition of the prepaid dental plan:]*

[(A) Premiums receivable net of bad debt allowance when the receivable is greater than ninety (90) days past due,

except as allowed in paragraph (1)(B)3.;

(B) Prepaid expenses, except as allowed in paragraph (1)(B)6.;

(C) Security deposits;

(D) Automobiles;

(E) Office furniture and equipment;

(F) Computer software;

(G) Letters of credit, except to secure reinsurance credit as outlined in section 375.246, RSMo, pledges to purchase stock or other guarantees by outside organizations;

(H) Capital leases; and

(I) Any asset expressly disapproved in writing by the director.]

(3) Liabilities shall be determined *[by the instructions to the National Association of Insurance Commissioners (NAIC) blank annual statement form for health maintenance organizations or any blank annual statement forms designed specifically for prepaid dental plans except the following need not be reflected as liabilities:]* **in accordance with the statements.**

[(A) Capital leases; and

(B) Any debt subordinated and approved pursuant to 20 CSR 200-1.070.]

(4) *[In lieu of the examination by the director or any of his/her duly appointed agents, the director may accept a full report of an examination or audit of an independent certified public accountant. The report shall be based on the standards set out in this rule.]* **The director will consider compliance with the standards of section 375.539, RSMo when evaluating a prepaid dental plan under section 354.722, RSMo.**

AUTHORITY: *section 354.723, RSMo [2000] 2016. This rule was previously filed as 4 CSR 190-II.280. Original rule filed Dec. 12, 1989, effective April 1, 1990. Amended: Filed Dec. 14, 2000, effective July 30, 2001. Amended: Filed Oct. 30, 2018.*

PUBLIC COST: *This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

PRIVATE COST: *This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

NOTICE TO SUBMIT COMMENTS: *Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Meaghan Forck, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION

Division 200—Insurance Solvency and Company Regulation

Chapter 1—Financial Solvency and Accounting Standards

PROPOSED AMENDMENT

20 CSR 200-1.070 Subordinated Indebtedness. The director is amending sections (1)–(7) and amending the purpose statement.

PURPOSE: *This amendment modernizes the rule and removes outdated and unnecessary language.*

PURPOSE: This rule specifies information [which must] to be submitted to the director for prior approval of subordinated indebtedness agreements, the form [which] of consideration for these agreements [must take] and the accounting procedures to be followed. This rule implements sections 354.355, 354.480, 375.535, [375.540, 375.560 and 380.271] 375.539, and 381.075, RSMo.

(1) Application. This rule applies to all health service corporations, health maintenance organizations (HMOs), insurance companies, and reciprocal interinsurance exchanges organized under the laws of this state and is applicable to any debts other than those shown as a legal liability of the company. Notwithstanding any other provision to the contrary, no company or other entity which has the power to assess its members may issue any subordinated indebtedness unless it is a mutual company organized under [sections 379.205—379.310] **Chapter 379**, RSMo.

(2) Definition, Subordinated Indebtedness (Surplus Notes). Subordinated indebtedness, for the purposes of this rule includes any contingent obligation for the repayment of a sum of money upon a written agreement that the loan or advance with interest shall be repaid only out of surplus profits of the company [in excess of the minimum surplus as required by Missouri law and as shall be], as defined at **20 CSR 200-11.150(2)**, or as deemed necessary by the director of insurance to secure the interests of the policyholders and creditors of this company.

(3) Approval by the Director.

(A) The following shall be submitted to the director [of insurance] for **prior** approval:

1. Duplicate copies of the entire **subordinated** indebtedness agreement; and

2. Certified copy of the resolution of the board of directors [of proper company body] or committee which is empowered to authorize these agreements. The resolution shall stipulate the maximum amount of subordinated indebtedness authorized and the purpose for which it is incurred. It also shall limit the application of the proceeds to the specific purpose for which the **subordinated** indebtedness is incurred.

(B) After submission of the documents and approval, the director may authorize the execution of the **subordinated** indebtedness agreement. All agreements shall be executed and the consideration received immediately after the approval **unless otherwise stated in the approval order**.

(C) Any amendment to or cancellation of an approved subordinated indebtedness agreement is to be submitted to the director for prior approval in accordance with subsection (3)(A) of this rule.

(4) Consideration. The consideration tendered to the company in exchange for the agreement shall be [lawful money or other consideration as may be] in the form of cash or other admitted assets having readily determinable values and liquidity acceptable to and approved by the director.

(5) Reporting and Accounting of **Subordinated** Indebtedness.

(A) The director shall be notified immediately in writing upon the execution of any **subordinated** indebtedness agreement as to the amount and to whom payable.

[(B) Any existing subordinated indebtedness incurred prior to March 29, 1976, also shall be reported immediately in writing to the director.]

[(C)](B) All outstanding subordinated indebtedness and interest accruing shall be reported at face value in the annual statement on page 3 and in other financial statements of the company as a special surplus account. **Accrued interest that has not been approved for payment should be accounted for by debiting unassigned funds and crediting the special surplus account.**

(6) Approval of Repayment by Director. Repayment of principal or payment of interest may be made only with the approval of the director when s/he is satisfied that the financial condition of the company warrants this action. **Repayment of surplus note interest should first reverse any unapproved accrued interest accounting by debiting the special surplus account and crediting unassigned funds. The interest payment should then be recorded by debiting interest expense and crediting cash. Repayment of principal should follow the guidance set forth in the National Association of Insurance Commissioners' Accounting Practices and Procedures Manual.**

(7) Other Loans. Nothing in this section [shall] is to be construed to mean that a company [may not] **cannot** otherwise borrow money, but the amount so borrowed with accrued interest shall be carried by the company as a liability.

AUTHORITY: sections 354.120, 354.485, and 374.045, [and 380.561,] RSMo [1986] 2016. This rule was previously filed as 4 CSR 190-II.010. Original rule filed June 12, 1970, effective July 1, 1970. Amended: Filed Aug. 5, 1974, effective Aug. 15, 1974. Amended: Filed July 18, 1989, effective Nov. 1, 1989. Amended: Filed Oct. 30, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Meaghan Forck, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION

Division 200—Insurance Solvency and Company Regulation

Chapter 1—Financial Solvency and Accounting Standards

PROPOSED AMENDMENT

20 CSR 200-1.110 Qualifications of Actuary or Consulting Actuary. The director is amending sections (1)–(3) and (6), and amending the purpose statement.

PURPOSE: This amendment corrects a statutory reference and removes unnecessary language.

PURPOSE: This rule describes the necessary qualifications [required] of an actuary signing and certifying the life and accident and health annual statement of an insurer. This rule was adopted pursuant to the provisions of section 374.045, RSMo and implements section 376.350, RSMo.

(1) Every life insurance company authorized to do business in this state [is required to] files an annual statement. Missouri instructions for completing the life and accident and health annual statement blank require that these forms be signed and certified by a qualified actuary.

(2) For this purpose, a “qualified actuary” *[shall]* means a member in good standing of the American Academy of Actuaries.

(3) Scope. This rule *[shall apply]* **applies** to all reports, statements and other documents filed with the director or issued to the public in relation to the business of insurance.

(6) Annual Statements of Domestic Life Insurance Companies. Section [376.380] **376.350**, RSMo prescribes the general form of the annual statement which must be filed with the director each year. The form which is required by the director is that which has been developed by the National Association of Insurance Commissioners. This form now includes a requirement relating to policy reserves and other actuarial items. The instructions for completion of the blank describe the content of this requirement. The items on which actuarial opinion is required are—

AUTHORITY: sections 374.045 and 376.350, RSMo [2000] **2016**. This rule was previously filed as 4 CSR 190-II.080. Original rule filed Aug. 5, 1974, effective Aug. 15, 1974. Amended: Filed Aug. 16, 1977, effective Dec. 11, 1977. Amended: Filed Dec. 14, 2000, effective July 30, 2001. Amended: Filed Oct. 30, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Meaghan Forck, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 20—DEPARTMENT OF INSURANCE,
FINANCIAL INSTITUTIONS AND PROFESSIONAL
REGISTRATION
Division 200—Insurance Solvency and Company
Regulation
Chapter 1—Financial Solvency and Accounting Standards**

PROPOSED RESCISSION

20 CSR 200-1.120 Take-Out Letters. This rule stated requirements for insurance companies entering into take-out letters and similar contracts to provide after-construction financing of commercial buildings. This rule was adopted pursuant to the provisions of section 374.045, RSMo and implemented sections 376.300 and 379.080, RSMo.

PURPOSE: This rule is being rescinded because it has not been modified since its original filing in 1974 and is no longer necessary.

AUTHORITY: sections 374.045 and 379.080, RSMo Supp. 1993 and 376.300, RSMo 1986. This rule was previously filed as 4 CSR 190-II.100. Original rule filed Dec. 20, 1974, effective Dec. 30, 1974. Rescinded: Filed Oct. 30, 2018.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Meaghan Forck, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 20—DEPARTMENT OF INSURANCE,
FINANCIAL INSTITUTIONS AND PROFESSIONAL
REGISTRATION
Division 200—Insurance Solvency and Company
Regulation
Chapter 1—Financial Solvency and Accounting Standards**

PROPOSED RESCISSION

20 CSR 200-1.150 General Standards Applicable to Audited Financial Reports. This rule provided interpretations of various terms and provisions used in sections 375.1025—375.1062, RSMo which govern how the financial reports of insurers are to be audited.

PURPOSE: This rule is being rescinded because it largely conflicts with or duplicates Missouri statutes and is otherwise unnecessary.

AUTHORITY: sections 374.045, 375.1032, 375.1037, 375.1045, 375.013 and 375.1060 RSMo 1994. Original rule filed Aug. 11, 1992, effective May 6, 1993. Amended: Filed July 3, 1995, effective Feb. 25, 1996. Rescinded: Filed Oct. 30, 2018.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Meaghan Forck, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 20—DEPARTMENT OF INSURANCE,
FINANCIAL INSTITUTIONS AND PROFESSIONAL
REGISTRATION
Division 200—Insurance Solvency and Company
Regulation
Chapter 2—Reinsurance and Assumptions**

PROPOSED RESCISSION

20 CSR 200-2.200 Reinsurance—Lloyd’s, London, England. This rule described conditions for reinsuring with underwriters at Lloyd’s, London, England. This rule was adopted pursuant to the provisions of section 374.045, RSMo and implemented section 375.241, RSMo.

PURPOSE: This rule is being rescinded because it implements a statute that was repealed in 1993, and because it is no longer necessary.

AUTHORITY: sections 374.045, RSMo Supp. 1993 and 375.241, RSMo 1986. This rule was previously filed as 4 CSR 190-II.070. Original rule filed July 27, 1964, effective Aug. 6, 1964. Amended:

Filed Dec. 5, 1969, effective Dec. 15, 1969. Amended: Filed Aug. 5, 1974, effective Aug. 15, 1974. Rescinded: Filed Oct. 30, 2018.

PUBLIC COST: *This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

PRIVATE COST: *This proposed rescission will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

NOTICE TO SUBMIT COMMENTS: *Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Meaghan Forck, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**Title 20—DEPARTMENT OF INSURANCE,
FINANCIAL INSTITUTIONS AND PROFESSIONAL
REGISTRATION**

**Division 200—Insurance Solvency and Company
Regulation**

Chapter 2—Reinsurance and Assumptions

PROPOSED RESCISSION

20 CSR 200-2.700 Reinsurance Mirror Image Rule. This rule effectuated or aided in the interpretation of a law related to the business of insurance, section 375.246.5, RSMo.

PURPOSE: *This rule is being rescinded because it is no longer necessary.*

AUTHORITY: *section 374.045, RSMo 2000. Original rule filed Aug. 20, 1993, effective May 9, 1994. Amended: filed July 12, 2002, effective Feb. 28, 2003. Rescinded: Filed Oct. 30, 2018.*

PUBLIC COST: *This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

PRIVATE COST: *This proposed rescission will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

NOTICE TO SUBMIT COMMENTS: *Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Meaghan Forck, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**Title 20—DEPARTMENT OF INSURANCE,
FINANCIAL INSTITUTIONS AND PROFESSIONAL
REGISTRATION**

**Division 200—Insurance Solvency and Company
Regulation**

Chapter 2—Reinsurance and Assumptions

PROPOSED AMENDMENT

20 CSR 200-2.800 Assumption Reinsurance. The director is removing sections (1), (2), (5), and (7), and amending existing sections (3), (4), and (6).

PURPOSE: *This amendment restructures and simplifies the rule, and*

removes language that is unnecessary due to identical or similar statutory provisions.

[(1) Notice of transfer regarding an assumption reinsurance agreement pertaining to contracts of insurance owned by policyholders residing in the state of Missouri shall be in the form specified in section 375.1287.1(3), RSMo. The response card sent to the policyholder also shall be in the form identical to section 375.1287.1(3), RSMo.

(2) If either the transferring or the assuming insurer is a foreign insurance company and is from a state that has a reinsurance assumption law substantially similar to that of Missouri, then both insurers shall submit an affidavit stating that the transaction is subject to substantially similar requirements in their respective domiciliary states.]

[(3)](1) A summary in writing shall be submitted [setting forth all] addressing each of the factors in section 375.1287.2(5)(a)–(d) and (f), RSMo.

[(4)](2) If either the transferring insurer or the assuming insurer is a Missouri domestic, [both insurers shall submit] or is from a state that does not have a reinsurance assumption law substantially similar to that of Missouri, the following documentation shall be submitted to the [Department of Insurance] department for approval of the assumption:

(A) Certificate of Assumption;

(B) Copy of Notice of Transfer, including items referenced as attachments, and Response Card;

(C) Copy of Assumption Reinsurance Agreement and Approval from [any] all domiciliary states other than Missouri;

(D) [Ratings from the last five (5) years from two (2) nationally recognized rating services and the meaning of those ratings (if ratings are unavailable for any year of the five (5)-year period, this shall also be disclosed and explained)] Financial data pursuant to section 375.1287.1(2)(i), RSMo;

[(E) Balance sheet as of December 31 for the previous three (3) years and the most recent quarterly financial statement for both the transferring insurer and the assuming insurer;]

[(F)](E) Terms and type of financing related to the purchase price; and

[(G)](F) Pro forma financial statements reflecting the financial condition of both insurers before and after the proposed transaction as of the effective date of the transaction[;].

[(H) Copy of the insurers' Management's Discussion and Analysis that was filed as a supplement to the previous year's annual statement; and

(I) Explanation of the reason for the transfer.

(5) If either the transferring insurer or the assuming insurer is from a state that does not have a reinsurance assumption law substantially similar to that of Missouri, then both insurers shall submit the following documentation to the Department of Insurance for approval of the assumption:

(A) Certificate of Assumption;

(B) Copy of Notice of Transfer and Response Card;

(C) Copy of Assumption Reinsurance Agreement and Approvals from domiciliary states;

(D) Ratings from the last five (5) years from two (2) nationally recognized rating services and the meaning of those ratings (if ratings are unavailable for any year of the five (5)-year period, this shall also be disclosed and explained);

(E) Balance sheet as of December 31 for the previous three (3) years and the most recent quarterly financial statement for both the transferring insurer and the assuming

insurer;

(F) Terms and type of financing related to the purchase price;

(G) Pro forma financial statements reflecting the financial condition of both insurers before and after the proposed transaction as of the effective date of the transaction;

(H) Copy of the insurers' Management's Discussion and Analysis that was filed as a supplement to the previous year's annual statement; and

(I) Explanation of the reason for the transfer.]

[(6)](3) If both the transferring insurer and the assuming insurer are domiciled in states that have assumption reinsurance laws substantially similar to those of Missouri, then *[both insurers shall submit the following documentation to the Department of Insurance:] the filing requirements of subsections (2)(A)–(C) of this rule apply.*

[(A) Certificate of Assumption;

(B) Copy of the Notice of Transfer and Response Card; and

(C) Copy of Assumption Reinsurance Agreement and Approvals from the domiciliary states of the transferring insurer and the assuming insurer.]

[(7) With respect to section 375.1285(5), RSMo—

(A) The term certificate shall mean the terms of a group policy as applicable to an individual insured under the group policy; and

(B) A certificate holder shall be provided notice pursuant to section 375.1287, RSMo if the certificate holder is entitled to maintain the same terms of coverage without change in benefit in the event that the group policy is terminated.]

AUTHORITY: section 374.045, RSMo [Supp. 1993] 2016. Original rule filed[:] Feb. 16, 1994, effective Sept. 30, 1994. Amended: Filed Oct. 30, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Meaghan Forck, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION

Division 200—Insurance Solvency and Company Regulation

Chapter 3—Insurance Taxes Other Than Surplus Lines

PROPOSED AMENDMENT

20 CSR 200-3.010 Reporting of Flexible Payment Deferred Annuity Contract Premiums. The director is amending sections (1) and (3), and amending the purpose statement.

PURPOSE: This amendment removes unnecessary and outdated language from the rule.

PURPOSE: This rule recognizes that flexible payment deferred annu-

ities differ from traditional fully guaranteed fixed-premium, fixed-benefit annuity contracts in that[—] the full risk on the contract may [not] be indeterminable and [may] not attach to the insurer[;], and the total premium is not paid until it is applied to provide annuity payment. [This rule was adopted pursuant to the provisions of section 374.045, RSMo and to implement sections 148.310, 148.320, 148.330, 148.340, 148.350, 148.360, 148.370, 148.380, 148.390, 148.400, 148.410, 148.420, 148.430 and 376.350, RSMo.]

(1) Definition. A flexible payment deferred annuity is defined as a contract which provides for the payment of a guaranteed or variable annuity, or both, with the amount of the annuity determined[,] not at date of issue[,] but at the annuity commencement date **and** by the value at that time of the total payments made. The number of these payments are not specified in the contract, but are determined by the contract holder within a range acceptable to the insurance company. These contracts may also specify guaranteed minimum nonforfeiture values and annuity rate guarantees either for the life of the contract or guaranteed lesser period. *[All these contracts must be approved by the Missouri Department of Insurance.]*

(3) Insurers Previously Reporting Under Paid-In Approach.

(B) *[Each insurer shall signify on its premium tax return covering premiums for the calendar year 1975 the method it is currently using to report premiums received under flexible payment deferred annuities.]* If an insurer using the paid-in approach subsequently adopts the pay-out approach or vice versa, it shall so signify on the premium tax return covering premiums for that calendar year.

AUTHORITY: sections 148.310, 148.320, 148.330, 148.340, 148.350, 148.360, 148.370, 148.380, 148.390, 148.400, 148.410, 148.420, 148.430, 374.045, and 376.350, [RSMo 1986 and 148.360,] RSMo [Supp. 1990] 2016. This rule was previously filed as 4 CSR 190-11.130. Original rule filed Dec. 23, 1975, effective Jan. 2, 1976. Amended: Filed Oct. 30, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Meaghan Forck, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION

Division 200—Insurance Solvency and Company Regulation

Chapter 3—Insurance Taxes Other Than Surplus Lines

PROPOSED AMENDMENT

20 CSR 200-3.200 New Business Facility Tax Credit. The director is deleting section (2) and amending existing section (4).

PURPOSE: This amendment removes unnecessary and erroneous language from the rule.

[(2) The new business facility tax credit shall not be subject to subsection 375.916.1., RSMo, that is this credit shall not be subject to the retaliatory tax.]

[(3)](2) To the extent the amount of the new business facility tax credit exceeds the amount necessary to reduce the net Missouri premium tax due to zero (0), this excess may be applied as a credit against any retaliatory tax amount otherwise due.

[(4)](3) If an insurance company, which is also a taxpayer, has income derived from the operation of a new business facility as well as from other activities conducted with this state, the direct premiums derived by the insurance company from the operation of the new business facility [shall be] is determined by multiplying the insurance company's direct premiums, computed in accordance with Chapter 148, RSMo, by a fraction, the numerator of which is the property factor, as defined in subsection [(4)(A)] (3)(A) of this rule, plus the payroll factor, as defined in subsection [(4)(B)] (3)(B) of this [section] rule, and the [demoninator] denominator which is two (2)—

(A) The property factor is a fraction, the numerator of which is the new business facility investment certified for the tax period, and the denominator of which is the average value of all the taxpayer's real and depreciable tangible personal property owned or rented and used in this state during the tax period. The average value of all this property [shall be] is determined as provided in Chapter 32, RSMo; and

(B) The payroll factor is a fraction, the numerator of which is the total amount paid during the tax period by the taxpayer for compensation to persons qualifying as new business facility employees, as determined by section 135.110.4., RSMo at the new business facility, and the [demoninator] denominator of which is the total amount paid in this state during the tax period by the taxpayer for compensation. The compensation paid in this state [shall be] is determined as provided in Chapter 32, RSMo. For the purpose of this section, other activities conducted within this state [shall] include activities previously conducted at any time during the tax period immediately prior to the tax period in which commencement of commercial operations occurred.

AUTHORITY: sections 135.150[, RSMo Supp. 1991] and 374.045, RSMo [1986] 2016. Original rule filed June 18, 1993, effective Jan. 1, 1994. Amended: Filed Oct. 30, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Meaghan Forck, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 20—DEPARTMENT OF INSURANCE,
FINANCIAL INSTITUTIONS AND PROFESSIONAL
REGISTRATION
Division 200—Insurance Solvency and Company
Regulation
Chapter 4—Record Retention for Financial Audits**

PROPOSED AMENDMENT

20 CSR 200-4.010 Books, Records, Accounts and Vouchers. The director is amending sections (1), (2), and (4), and amending the purpose statement.

PURPOSE: This amendment updates the rule to comport with modern record formats and retention capabilities.

PURPOSE: This regulation describes the requirements for record-keeping for insurance companies and related entities doing business in this state. This regulation was adopted pursuant to the provisions of section 374.045, RSMo [1986] 2016 and to implement sections 144.027, 287.350, 354.190, 354.465, 354.717, 374.190, 374.205, 374.210, 375.149, 375.150, 375.151, 375.938, 375.1009, 376.1082, 379.343 and 379.475, RSMo [1986 and 144.027, 354.149, 354.717, 375.150, 375.151, 375.926 and 375.938 RSMo (Cum. Supp. 1991)] 2016.

(1) Records *[Required] to be Maintained* for Purposes of Financial Examinations. Every *[insurer, which term shall include every]* domestic insurer, foreign insurer, health services corporation, health maintenance organization, prepaid dental plan, managing general agent, and third-party administrator licensed to do business in this state shall maintain its books, records, documents, and other business records in an order that the insurer's financial condition may be readily ascertained by the *[Department of Insurance] department*, taking into consideration other record retention requirements. All such records must be maintained for not less than three (3) years, **or, for domestic insurers, health services corporations, health maintenance organizations, and prepaid dental plans, until the full-scope financial examination reviewing the time period that the record relates to is closed, whichever is longer.**

(2) Form of Record. *[Photographs, microfilms] Electronic* or other image-processing reproductions of records shall be equivalent to the originals and may be certified as same in actions or proceedings before the *[Department of Insurance] department* unless inconsistent with *[20 CSR 800-1.100] department rules governing the action or proceeding*. However, the maintenance *[or] of* records in a computer-based format shall be archival in nature only, so as to preclude the possibility of alteration of the contents of the record by computer after the initial transfer of the record to this format. In addition, all records must be capable of duplication to hard copy upon the request of a financial examiner.

(4) Time Limits. The insurer shall provide, within five (5) working days, any record requested by any duly appointed financial examiner of the director conducting an on-site financial examination. When the requested record is not or cannot be produced by the insurer within five (5) working days, the nonproduction *[shall be deemed a violation of] violates* this rule, unless the insurer can demonstrate to the satisfaction of the director that there is a reasonable justification for that delay.

AUTHORITY: sections 144.027, 287.350, 354.190, 354.465, 354.717, 374.045, 374.190, 374.205, 374.210, 375.149, 375.150, 375.151, 375.938, 375.1009, 376.1082, 379.343 and 379.475, RSMo [1986] 2016 [and 144.027, 354.717, 375.149, 375.150, 375.151, 375.926 and 375.938, RSMo Supp. 1991]. This rule was previously filed as 4 CSR 190-II.050. Original rule filed Dec. 20, 1974, effective Dec. 30, 1974. Amended: Filed Sept. 5, 1975, effective Sept. 15, 1975. Amended: Filed April 4, 1991, effective Oct. 31, 1991. Amended: Filed Oct. 30, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Meaghan Forck, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 20—DEPARTMENT OF INSURANCE,
FINANCIAL INSTITUTIONS AND PROFESSIONAL
REGISTRATION**

**Division 200—Insurance Solvency and Company
Regulation**

Chapter 5—Articles and Bylaws of Domestic Insurers

PROPOSED AMENDMENT

20 CSR 200-5.010 Amendment and Restatement of Articles. The director is amending sections (1) and (2), and deleting the two (2) appendices that follow the rule.

PURPOSE: This amendment simplifies and modernizes the rule, and amends the rule to provide for a streamlined process to amend and restate articles of incorporation or association.

(1) Forms.

[(A) FORM5.DOC shall be the f]Forms to be used by any insurance company organized or incorporated under the laws of this state to amend, restate, or amend and restate its articles of incorporation or association, if that company is subject to sections 375.201–[375.221] 375.226, RSMo, are available on the department's website or by contacting the department.

[(B) FORM7.DOC shall be the form used by any insurance company organized or incorporated under the laws of this state to restate its articles of incorporation or association, if that company is subject to section 375.226, RSMo.

(C) Any insurance company organized or incorporated under the laws of this state and subject to sections 375.201–375.226, RSMo which amends and restates its articles of incorporation or association shall first amend its articles using FORM5.DOC and then restate its articles as amended using FORM7.DOC.

(D) Copies of FORM5.DOC and FORM7.DOC may be obtained from the Admissions Specialist, Financial Examination Section. Copies may be freely duplicated. Appendices 1 and 2, as they appear in this rule, are representative of FORM5.DOC and FORM7.DOC, respectively, but are not in a form suitable for filing.]

(2) Procedures.

(C) Amending and restating the articles of incorporation or association of an insurance company organized or incorporated under the laws of this state may be accomplished simultaneously.

AUTHORITY: section 374.045[.1(2)], RSMo [Supp. 1998] 2016. This rule was previously filed as 4 CSR 190-11.330. Original rule filed Sept. 18, 1990, effective Feb. 14, 1991. Amended: Filed Jan. 8, 1991, effective June 10, 1991. Amended: Filed April 23, 1999, effective Nov. 30, 1999. Amended: Filed Oct. 30, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional

Registration, Attention: Meaghan Forck, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 20—DEPARTMENT OF INSURANCE,
FINANCIAL INSTITUTIONS AND PROFESSIONAL
REGISTRATION**

**Division 200—Insurance Solvency and Company
Regulation**

Chapter 17—Admissions

PROPOSED AMENDMENT

20 CSR 200-17.200 Procedure for Foreign Insurer to Obtain a Certificate of Authority to Transact the Business of Insurance. The director is amending sections (1) and (3).

PURPOSE: This amendment removes outdated language.

(1) Any foreign insurance company, as that term is used in section 375.811, RSMo, making application to the director of the [Department of Insurance] department for a certificate of authority to transact an insurance business in the state of Missouri shall do so by filing both of the following:

(B) Additional information as follows:

[1. A letter from the insurance commissioner of the applicant's domicile state stating that according to his/her records, the applicant is prompt and equitable in its loss payments to policyholders and payments are in accordance with policy provisions;]

[2.]1. A narrative description of the history of the applicant;

[3.]2. Explanation of any unique assets, liabilities, or operating aspects of the applicant; and

[4.]3. A detailed explanation of any present controversy with any state or federal regulatory agency or of any presently pending formal or informal hearings.

(3) Upon request, the [Missouri Department of Insurance] department will provide information regarding:

AUTHORITY: section 374.045, RSMo [2000] 2016. Original rule filed June 14, 2001, effective Dec. 30, 2001. Amended: Filed Oct. 30, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Terra Sapp, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 20—DEPARTMENT OF INSURANCE,
FINANCIAL INSTITUTIONS AND PROFESSIONAL
REGISTRATION**

**Division 200—Insurance Solvency and Company
Regulation**

Chapter 19—Discount Medical Plans

PROPOSED AMENDMENT

20 CSR 200-19.020 Scope and Definitions. The director is amending

sections (1) and (2).

PURPOSE: This amendment updates and removes unnecessary language.

(1) *[Applicability of Rules.]* The rules in this chapter apply to discount medical plan organizations transacting business under sections 376.1500 to 376.1532, RSMo. The rules *[shall]* **are to** be read together with Chapter 536, RSMo.

(2) *[Definitions.]* **The definitions located in section 376.1500, RSMo apply to the rules in this chapter.**

[(A) "Director," the director of the department;

(B) "Department," the department of insurance, financial institutions and professional registration.]

AUTHORITY: sections 374.045[, RSMo 2000] and [section] 376.1528, RSMo [Supp. 2007] 2016. Original rule filed Nov. 1, 2007, effective June 30, 2008. Amended: Filed Oct. 30, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Terra Sapp, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION

Division 200—Insurance Solvency and Company Regulation

Chapter 19—Discount Medical Plans

PROPOSED AMENDMENT

20 CSR 200-19.050 Registration. The director is amending sections (1)–(3).

PURPOSE: This amendment modifies and removes unnecessary language.

(1) Registration Forms. The following form has been adopted and approved for filing with the department:

(A) The Discount Medical Plan Organization Registration form (Form DM-1)*[, or any form which substantially comports with the specified form].*

(2) Application and Fees.

(A) Initial Registration. Each *["discount medical plan organization," as that term is used in sections 376.1500 to 376.1532, RSMo,]* shall register with the director by:

1. *[Completing] Completion* and filing of a Form DM-1 in accordance with the instructions contained therein;

2. Payment of **the** two hundred fifty dollar (\$250) registration fee; and

3. Demonstration of compliance with **the** net worth requirement under rule 20 CSR 200-19.060.

(B) Renewal Registration. Each discount medical plan organization *[shall]* **may** renew its registration between thirty (30) days prior to and the anniversary date of its initial registration by *[:]*—

1. *[Submitting] Submission* of any amendments to the Form DM-1;

2. Payment of **the** two hundred fifty dollar (\$250) annual registration fee; and

3. Demonstration of compliance with **the** net worth requirement under rule 20 CSR 200-19.060.

(3) Copies of the Form DM-1 may be obtained from *[the director at the department's office in Jefferson City, Missouri, on]* the department's web site, www.insurance.mo.gov *[or by mailing a written request to the department at Attention: Admissions Specialist, Department of Insurance, Financial Institutions and Professional Registration, PO Box 690, Jefferson City, MO 65102].*

AUTHORITY: sections 374.045, [RSMo 2000 and sections] 376.1504, and 376.1528, RSMo [Supp. 2007] 2016. Original rule filed Nov. 1, 2007, effective June 30, 2008. Amended: Filed Oct. 30, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Terra Sapp, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION

Division 400—Life, Annuities and Health Chapter 6—Health Services Corporations

PROPOSED AMENDMENT

20 CSR 400-6.100 Establishment and Computation of Reserves. The director is amending sections (2) and (3), and amending the purpose statement.

PURPOSE: This amendment removes outdated language.

PURPOSE: This regulation describes the method of establishment and computation of reserves for health services corporations. This regulation is adopted pursuant to section 354.120, RSMo [1986] and to implement section 354.080, RSMo [1986].

(2) Factors to be Considered in Reducing this Reserve Requirement.

(A) The primary consideration in any reductions of reserves *[must]* **will** be the security for payment of the benefits stated in the membership contract. Any factors which would provide security for payment comparable to the reserve *[shall]* **will** be considered.

(3) Reduction of Reserves.

[[A]] Any health service corporation subject to Chapter 354, RSMo may petition the director *[of insurance]* to reduce *[or suspend]* the *[financial reserves required by]* section 354.080, RSMo **financial reserve requirements pursuant to section 374.055, RSMo. [The**

director shall give ten (10) days' notice of the hearing to the petitioning corporation and hear the matter pursuant to the provisions of 20 CSR 800-1.010.]

[(B) The director shall issue an order subsequent to the hearing based upon the best interests of the members and beneficiaries of the petitioning corporation. The order must state the factual bases and any other factors considered in permitting or refusing any decrease or suspension of reserve requirements.]

AUTHORITY: sections 354.080 and 354.120, RSMo [1986] 2016. This rule was previously filed as 4 CSR 190-15.010. Original rule filed Sept. 19, 1974, effective Sept. 29, 1974. Amended: Filed Oct. 30, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Terra Sapp, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION

Division 500—Property and Casualty Chapter 10—Mortgage Guaranty Insurance

PROPOSED RESCISSION

20 CSR 500-10.100 Definitions. This rule defined terms and explained usage for those terms used in this chapter. This regulation implemented section 379.010, RSMo.

PURPOSE: This rule is being rescinded because it is unnecessary.

AUTHORITY: sections 374.045, RSMo 2000 and 443.415, RSMo Supp. 2002. Original rule filed April 11, 1996, effective Nov. 30, 1996. Amended: Filed Aug. 31, 2000, effective April 30, 2001. Amended: Filed Nov. 1, 2002, effective July 30, 2003. Rescinded: Filed Oct. 30, 2018.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Terra Sapp, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION

Division 500—Property and Casualty Chapter 10—Mortgage Guaranty Insurance

PROPOSED RESCISSION

20 CSR 500-10.200 Financial Regulation. This rule defined terms and explained usage for those terms used in this chapter. This regulation implemented section 379.010, RSMo.

PURPOSE: This rule is being rescinded because it is unnecessary.

AUTHORITY: section 374.045, RSMo Supp. 2009. Original rule filed April 11, 1996, effective Nov. 30, 1996. Amended: Filed Dec. 14, 2000, effective July 30, 2001. Amended: Filed April 15, 2010, effective Dec. 30, 2010. Rescinded: Filed Oct. 30, 2018.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Terra Sapp, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION

Division 500—Property and Casualty Chapter 10—Mortgage Guaranty Insurance

PROPOSED RESCISSION

20 CSR 500-10.300 Unfair Acts or Practices. This rule carried out and effectuated the provisions of sections 375.930-375.948, RSMo (1994), as such sections apply to mortgage guaranty insurance.

PURPOSE: This rule is being rescinded because it is not supported by the authorizing statute.

AUTHORITY: section 375.948, RSMo 1994. Original rule filed April 11, 1996, effective Nov. 30, 1996. Amended: Filed Aug. 31, 2000, effective April 30, 2001. Rescinded: Filed Oct. 30, 2018.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Kelly A. Hopper, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 20—DEPARTMENT OF INSURANCE,
FINANCIAL INSTITUTIONS AND PROFESSIONAL
REGISTRATION**

**Division 500—Property and Casualty
Chapter 10—Mortgage Guaranty Insurance**

PROPOSED RESCISSION

20 CSR 500-10.400 Policy Rates and Forms. This rule effectuated sections 379.420 to 379.510, RSMo (1994), as such sections applied to mortgage guaranty insurance.

PURPOSE: This rule is being rescinded because it is unnecessary.

AUTHORITY: section 374.045, RSMo 1994. Original rule filed April 11, 1996, effective Nov. 30, 1996. Rescinded: Filed Oct. 30, 2018.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Terra Sapp, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 20—DEPARTMENT OF INSURANCE,
FINANCIAL INSTITUTIONS AND PROFESSIONAL
REGISTRATION**

**Division 800—Administrative Procedures under the
Insurance Laws
Chapter 3—Mergers and Acquisitions**

PROPOSED AMENDMENT

20 CSR 800-3.010 Definitions. The director is amending sections (1) and (2).

PURPOSE: This amendment updates the rule to reflect an additional type of merger and acquisition proceeding, clarifies language, and removes unnecessary definitions.

(1) Applicability of Rules. The rules in this chapter apply to all hearings conducted pursuant to the merger and acquisition review procedures in sections 375.355 [and], 382.060, and **382.095**, RSMo and are governed by Chapter 536, RSMo. The rules [shall] are to be read together with Chapter 536, RSMo.

(2) Definitions.

[(A)](A) "Certificate of Authority" the whole or part of any certificate of approval or charter granted by the director for any insurance company, insurer, association, health services corporation, health maintenance organization, or other legal entity insuring risk.]

[(B)](A) "Director" the director of the department.

[(C)](B) "Department" means the Department of Insurance, Financial Institutions and Professional Registration.

[(D)](C) "Party" any individual, partnership, corporation, association, public or private organization of any character or any other governmental agency properly requesting a hearing, named as a respondent, seeking to be heard or entitled to intervene in any matter under the rules in this chapter. **Any division of the department is**

entitled to act as a party in any matter under the rules of this chapter.

[(E)] "Respondent" any party in an administrative proceeding before the director under sections 375.355 and 382.060, RSMo.]

AUTHORITY: section 374.045, RSMo [2000] 2016. Original rule filed Sept. 5, 2007, effective May 30, 2008. Amended: Filed Oct. 30, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Terra Sapp, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 20—DEPARTMENT OF INSURANCE,
FINANCIAL INSTITUTIONS AND PROFESSIONAL
REGISTRATION**

**Division 800—Administrative Procedures under the
Insurance Laws
Chapter 3—Mergers and Acquisitions**

PROPOSED AMENDMENT

20 CSR 800-3.020 General Procedures. The director is amending sections (1) and (2) and (4)–(9).

PURPOSE: This amendment clarifies and modernizes the rule.

(1) Rules of Procedure. The hearings before the director pursuant to sections 375.355 [and], 382.060, and **382.095**, RSMo are governed by **the rules of this chapter, the rules of Division 800, Chapter 1 concerning contested case proceedings, and Chapter 536, RSMo.**

(2) Place of Filing. If the matter is to be heard by the director, all pleadings, documents, and requests [permitted or required] to be filed with the department in connection with a hearing shall be delivered, mailed, addressed, or submitted to or filed with the director at the Department of Insurance, Financial Institutions and Professional Registration, PO Box 690, 301 West High Street, Jefferson City, MO 65102. The party filing pleadings or documents shall serve by mail copies of all filed pleadings or documents on all parties.

(4) Form of Documents.

(A) Except as otherwise provided, one (1) original and [four (4)] **two (2)** copies of all documents **initiating proceedings** shall be signed by the party or by his/her authorized representative or attorney and filed with the director.

(5) Computation of Time.

(A) In computing any period of time prescribed or allowed by this regulation or by any applicable statute, the day of the act, event, or default after which the designated period of time begins to run is not to be included. The last day of the period so computed is to be included, unless it is a Saturday, Sunday, or legal holiday, in which event the period runs until the end of the next day that is neither a Saturday, Sunday, nor a legal holiday. When the period of time prescribed or allowed is less than seven (7) days, intermediate Saturdays,

Sundays, and legal holidays *[shall be]* are excluded in the computation.

(B) Notice requirements *[shall be]* are construed to mean notice received, but proof that notice was dispatched by means reasonably calculated to be received by the prescribed date *[shall be]* is prima facie evidence that notice was timely received.

(6) Appearance.

(A) Any person entitled to participate in any proceedings may appear as follows:

1. A natural person may appear on his/her own behalf or by an attorney at law licensed to practice in Missouri or both; *[and]*

2. A division of the department may appear by an attorney at law licensed to practice in Missouri; and

2./3. A corporation, association, or other entity shall be represented by an attorney licensed to practice in Missouri, except a bona fide officer, employee, or representative may appear on behalf of such entities for preliminary matters until such time as an attorney is retained.

(C) An attorney appearing in a representative capacity shall file a written *[notice]* entry of appearance.

(7) Presiding Officer. The director has the authority to conduct a hearing, take all necessary action to avoid delay, maintain order, and insure the development of a clear and complete record. The director possesses all powers necessary to conduct a hearing including, but not limited to, the power to—

(B) Regulate the course of hearings, set the time and place for continued hearings, fix times for filing of documents, provide for the taking of testimony by deposition if necessary, and generally conduct the proceedings according to generally recognized administrative law and this regulation;

(C) Examine witnesses and direct witnesses to testify, limit the number of times any witness may testify, limit repetitious or cumulative testimony, and set reasonable limits on the amount of time each witness may testify;

(E) Sign and issue subpoenas that require attendance giving testimony and the production of books, papers, and other documentary evidence;

(H) Render findings of fact, conclusions of law, decisions, and orders;

(I) Order the filing of written direct testimony by *[all parties]* any party to a hearing. Written direct testimony, if ordered to be filed, shall be on eight and one-half inch by eleven inch (8 1/2" × 11") paper, in question and answer form and the truth sworn to before a notary public. *[Written direct testimony, if ordered to be filed, shall be in lieu of all live direct testimony except redirect or rebuttal testimony or if good cause is shown to the director.]* The right to cross-examination of any witness on whose behalf written direct testimony is filed is mandatory; and

(8) Transcription of Proceedings.

(A) Oral proceedings at which evidence is presented *[shall]* will be recorded *[either]* and transcribed by a certified court reporter *[or a mechanical recording device, but need not be transcribed unless requested by a party who shall pay for the transcription of the portion requested]*, except as otherwise provided by law. Any transcription will be retained through and including the time allotted for appeal, revision, rehearing, or other manner of review prior to final disposition as provided for by law.

(B) The transcript and the record offered in connection with the hearing *[shall]* constitute the official record. *[Before the transcript is filed, the director shall notify the parties that the transcript has been produced, receive corrections from any person, examine the transcript for accuracy and then within a reasonable time certify that it is a true and correct transcript of the hearing. Only after the certification may the transcript be made available for public inspection as the director may allow.]*

(C) The record in an administrative hearing shall include: pre-hearing records; all pleadings (including all notices and answers, motions, and briefs); evidence received; a statement of matters officially noticed; offers of proof, objections, and rulings; all orders entered by the director; and findings, conclusions, opinions, recommendations, and final order of the director.

(9) Existing Statutory or Department Procedures and Practices. This regulation *[shall]* is not to be construed to limit or repeal additional requirements imposed by statute or otherwise or to change existing department procedures which are equivalent to or exceed the standards of administrative procedure prescribed in this regulation.

AUTHORITY: section 374.045, RSMo [2000] 2016. Original rule filed Sept. 5, 2007, effective May 30, 2008. Amended: Filed Oct. 30, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Terra Sapp, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 20—DEPARTMENT OF INSURANCE,
FINANCIAL INSTITUTIONS AND PROFESSIONAL
REGISTRATION
Division 2070—State Board of Chiropractic Examiners
Chapter 3—Preceptorship**

PROPOSED RESCISSION

20 CSR 2070-3.010 Preceptorship. This rule allowed preceptorship programs by approved chiropractic colleges and explained the allowable activities by interns.

PURPOSE: This rule is being rescinded because chiropractic colleges and universities are responsible for selecting and screening preceptors for chiropractic students, therefore the rule is no longer necessary.

AUTHORITY: section 331.100.2, RSMo 2000. This rule originally filed as 4 CSR 70-3.010. Original rule filed April 16, 1990, effective June 30, 1990. For intervening history, please consult the *Code of State Regulations*. Rescinded: Filed Oct. 23, 2018.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the State Board of Chiropractic Examiners, PO Box 672, Jefferson City, MO 65102-0672, by facsimile at (573) 751-0735, or via email at chiropractic@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 1—General Organization**

PROPOSED RULE

22 CSR 10-1.030 Board of Trustees Election Process

PURPOSE: This rule establishes the policy of the board of trustees in regard to election of board members by the subscribers of the Missouri Consolidated Health Care Plan.

(1) The subscribers of the Missouri Consolidated Health Care Plan (MCHCP) shall elect two (2) active employee members and one (1) retiree member to the board of trustees. Each member will serve a term of four (4) years from the first day of January following their election.

(2) Board Member Candidate Eligibility.

(A) Candidates must be a subscriber of the plan.

(B) A candidate who is running for a position on the board as an active employee member must be employed on the date the nominating petitions are due. Failure to be employed at that time will result in an automatic disqualification.

(C) A candidate who is running for a position on the board as a retiree member must be retired on the date that the nominating petitions are due. Failure to be retired at that time will result in an automatic disqualification.

(D) The following members are not eligible candidates:

1. Current employees of the plan;
2. Immediate relatives of persons employed by the plan.

Immediate relatives include:

- A. Employee's spouse;
- B. Children of employee or spouse;
- C. Parents of employee or spouse;
- D. Brothers and sisters of employee, including brothers-in-law and sisters-in-law;
- E. Grandchildren (including great-grandchildren) of employee or spouse;
- F. Grandparents (including great-grandparents) of employee or spouse; and
- G. Members of the employee's household.

(E) It will be automatic grounds for disqualification if it is determined that a candidate knowingly submitted false information in the election process.

(3) Nomination Process.

(A) Candidates will be nominated by means of a nominating petition.

(B) The plan will notify subscribers of an opening for a board position.

(C) Candidates may only run for one (1) position on the board.

(D) Candidates must download from MCHCP's website, complete, and submit in a manner indicated by the plan, a valid nominating petition by a date determined by the plan. Valid nominating petitions include:

1. Candidate Information, including but not limited to, name, department, and resume;
2. Information to solicit the candidate's interest in health care issues;
3. Information to solicit any disqualifying information of the candidate;
4. A summary of information regarding the candidate's background and qualifications, for example: years of state service, department experience, and reasons for wanting to be on the board. The summary shall not exceed three hundred (300) words and will be used on the voting website. Formatting of this information for the board election ballot materials will be under the direction of the plan;

and

5. Any additional information as determined by the plan which is important to the nominating and voting process.

(E) Board member candidates may not use state resources (equipment, personnel, and supplies) for campaign purposes. Board member candidates may not use interagency mail or send email from a computer provided by the state to distribute campaign materials. State agencies, at their discretion, may allow the posting of campaign materials provided by the candidates on an equal time basis.

(F) Board candidates may not use the plan's resources for campaign purposes. This includes receiving demographic information of the plan's members, including but not limited to, member names, phone numbers, addresses, and email addresses.

(G) The plan will establish procedures to ensure candidate information is true and accurate. These procedures will include, but may not be limited to, validation of the information on the candidate petition forms.

(H) If only one (1) valid nominating petition is filed for any vacancy, the person nominated will be declared elected by the board at the next regular board meeting.

(I) If at least one (1) valid nominating petition is not filed for each vacancy to be filled, this election process shall be repeated for that vacancy until a valid nominating petition is received.

(4) Election Ballots and Results.

(A) The plan will notify members of an election voting period in advance of the start of the voting period in the year of the board election.

(B) The voting period will be at least fourteen (14) calendar days in length. The beginning date of the voting period will be set by MCHCP's Executive Director.

(C) Voters must be a subscriber of the plan as of the last day of the month preceding the month in which the election is to be held.

(D) Names of candidates will be listed on the website or in a supplemental publication in random order at the discretion of the plan. In no event will names of candidates be placed in alphabetical order on the election ballot or in a supplemental publication other than by happenstance.

(E) All board election voting will be completed through the eligible subscriber's myMCHCP account. Access to computers for voting use will be available at MCHCP during normal business hours. Ballots not submitted through a myMCHCP account are invalid. An eligible subscriber may only vote once per election.

(F) Voting will cease at midnight Missouri time on the last day of the board election.

(G) Ballots for an active employee member election will allow selection of one (1) or two (2) active employee member candidates to become board members depending on the number of positions up for election. If the election is for two (2) board positions, the two (2) candidates receiving the highest number of votes will be declared elected. If the election is for one (1) board position, the candidate receiving the highest number of votes will be declared elected. If a tie occurs between two (2) or more candidates receiving an identical number of votes, the winner shall be determined by a toss of a coin.

(H) Ballots for retiree members will allow selection for one (1) retiree member candidate to become a board member. The one (1) candidate receiving the highest number of votes will be declared elected. If a tie occurs between two (2) or more candidates receiving an identical number of votes, the winner shall be determined by a toss of a coin.

(I) The Executive Director will administer any online balloting procedures, record all votes, and declare election results.

(J) The election results will be posted within forty-eight (48) hours of the official certification of the election by the plan. Voting records will be maintained by the Executive Director for a period of one (1) year. After one (1) year from the date of the certification of the results, voting information will be destroyed.

(K) Newly elected board members will begin their terms upon certification of the election.

(5) Qualifications for Board Members.

(A) The winning candidate(s) shall file a personal financial disclosure per RSMo, 103.008 within thirty (30) days of their election to the board.

(B) A board member representing active employee members must be employed on January 1 of each year following the election. Failure to be employed at that time will result in their resignation from the board.

(C) A board member representing active employee members who terminates employment with a covered agency for more than thirty (30) consecutive days while serving on the board will be considered to have resigned from the board. The election process will begin to fill the vacant seat within ninety (90) days of the resignation.

(D) A candidate who is running for a position on the board as a retiree member must be retired on January 1 of each year following the election. Failure to be retired at that time will result in an automatic disqualification.

(E) A retiree board member who becomes employed in a MCHCP benefit eligible position while serving on the board will be considered to have resigned from the board. The election process will begin to fill the vacant seat within ninety (90) days of the resignation.

(6) Vacancies. If a vacancy occurs at any time in the three (3) elected seats, election procedures will begin to take place within ninety (90) days of the vacancy.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Original rule filed Oct. 31, 2018.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN

Division 10—Health Care Plan Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.010 Definitions. The Missouri Consolidated Health Care Plan is amending sections (19), (29), (39), (51) and (52), deleting section (74), and renumbering thereafter.

PURPOSE: This amendment revises the definitions of diabetes education, essential benefits, Health Savings Account Plan, network, and non-network; removes the definition of terminated vested subscriber because it is duplicative of section (79); and renumbers as necessary.

PURPOSE: This rule establishes the policy of the board of trustees in regard to the definitions of the Missouri Consolidated Health Care Plan relative to state members.

(19) Diabetes *[Education]* **Self-Management/Training.** A program prescribed by a provider and taught by a Certified Diabetes Educator

to educate and support members with diabetes.

(29) Essential benefits. The plan covers essential benefits as required by the Patient Protection and Affordable Care Act. Essential benefits include:

(J) Pediatric services, including oral and vision care—routine vision exam, dental care/accidental injury, *[immunizations]* **vaccinations**, preventive services, and newborn screenings.

(39) *[Health Savings Account (HSA)]* **High Deductible Health Plan.** A health plan with a higher deductible than a traditional health plan that, when combined with an HSA, provides a tax-advantaged way to help save for future medical expenses.

(51) Network. The *[facilities,]* providers, *[and suppliers]* the health insurer, or plan has contracted with to provide health care services **to members**.

(52) Non-network. The *[facilities,]* providers, *[and suppliers]* the health insurer, or plan does not contract with to provide health care services **to members. Some providers may be a part of secondary provider networks recognized by the vendor for non-network benefits.**

[[74] Terminated vested subscriber. A previous active employee eligible for a future retirement benefit from MOSERS, MPERS, or grandfathered for coverage under the plan by law.]

[[75]](74) Termination of coverage. The termination of medical, dental, or vision coverage initiated by the employer or required by MCHCP eligibility policies.

[[76]](75) Tobacco. Cigarettes, cigarette papers, clove cigarettes, cigars, smokeless tobacco, smoking tobacco, other form of tobacco products, or products made with tobacco substitute containing nicotine.

[[77]](76) Tobacco-free. A member has not used a tobacco product in at least the previous three (3) months and plans to remain tobacco-free in the future.

[[78]](77) Usual, customary, and reasonable. The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service.

[[79]](78) Vendor. The current applicable third-party administrators of MCHCP benefits or other services.

[[80]](79) Vested subscriber. An active employee eligible for coverage under the plan and eligible for future benefits from MOSERS, MPERS, or grandfathered for coverage under the plan by law.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Amended: Filed Oct. 31, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

PROPOSED AMENDMENT

22 CSR 10-2.020 General Membership Provisions. The Missouri Consolidated Health Care Plan is amending sections (2), (3), (5), (8), and (9).

PURPOSE: This amendment revises eligibility requirements, enrollment procedures, voluntary cancelation of coverage requirements, enrollment of a newborn child proof of eligibility procedures, disabled dependent documentation timeframes, leave of absence form, and payment timeframes.

PURPOSE: This rule establishes the policy of the board of trustees in regard to the general membership provisions of the Missouri Consolidated Health Care Plan.

(2) Eligibility Requirements.

(B) Retiree Coverage.

1. An employee may participate in an MCHCP plan when s/he retires if s/he receives a monthly retirement benefit from either MOSERS or from Public School Retirement System (PSRS) for state employment. The employee may elect coverage for him/herself and his/her spouse/child(ren), provided the employee and his/her spouse/child(ren) have been continuously covered for health care benefits—

A. Through MCHCP since the effective date of the last open enrollment period;

B. Through MCHCP since the initial date of eligibility; or

C. Through group or individual medical coverage for the six (6) months immediately prior to retirement. Proof of prior group or individual coverage (letter from previous insurance carrier or former employer with dates of effective coverage and list of persons covered) is required.

2. An employee may enroll him/herself and his/her spouse/child(ren) in an MCHCP dental and/or vision plan when s/he retires if s/he receives a monthly retirement benefit from MOSERS and was employed by the Missouri Department of Conservation.

3. An employee may enroll him/herself and his/her spouse/child(ren) in an MCHCP dental and/or vision plan when s/he retires if s/he receives a monthly retirement benefit from MPERS.

4. If the retiree's spouse is a state active employee or retiree and enrolled in MCHCP, both spouses may transfer to coverage under the plan in which his/her spouse is enrolled or from his/her spouse's coverage to his/her coverage at any time as long as both spouses are eligible for MCHCP coverage and their coverage is continuous.

5. If a retiree who is eligible for coverage elects not to be continuously covered for him/herself and spouse/child(ren) with MCHCP from the date first eligible, or does not apply for coverage for him/herself and spouse/child(ren) within thirty-one (31) days of his/her eligibility date, the retiree and his/her spouse/child(ren) shall not thereafter be eligible for coverage unless specified elsewhere herein.

6. An individual enrolled in another non-MCHCP Medicare Advantage (Part C) and/or Medicare Prescription Drug Plan (Part D) is not eligible for medical coverage.

(G) Dependent Coverage. Eligible dependents include:

1. Spouse.

A. State employees eligible for coverage under the Missouri Department of Transportation, Department of Conservation, or the Highway Patrol medical plans may not enroll as a spouse under MCHCP.

B. Active Employee Coverage of a Spouse.

(I) If both spouses are active state employees covered by MCHCP, each spouse must enroll separately.

C. Retiree Coverage of a Spouse.

(I) A state retiree may enroll as a spouse under an employee's coverage or elect coverage as a retiree.

(II) At retirement, an employee eligible for coverage under the Missouri Department of Transportation, Department of Conservation, or the Highway Patrol medical plans may enroll as a spouse under MCHCP;

2. Children.

A. Children may be covered through the end of the month in which they turn twenty-six (26) years old if they meet one (1) of the following criteria:

(I) Natural child of subscriber or spouse;

(II) Legally-adopted child of subscriber or spouse;

(III) Child legally placed for adoption of subscriber or spouse;

(IV) Stepchild of subscriber. Such child will continue to be considered a dependent after the stepchild relationship ends due to the death of the child's natural parent and subscriber's spouse;

(V) Foster child of subscriber or spouse. Such child will continue to be considered a dependent child after the foster child relationship ends by operation of law when the child ages out if the foster child relationship between the subscriber or spouse and the child was in effect the day before the child ages out;

(VI) Grandchild for whom the subscriber or spouse has legal guardianship or legal custody;

(VII) A child for whom the subscriber or spouse is the court-ordered legal guardian under a guardianship of a minor. Such child will continue to be considered a dependent child after the guardianship ends by operation of law when the child becomes eighteen (18) years old if the guardianship of a minor relationship between the subscriber or spouse and the child was in effect the day before the child became eighteen (18) years old;

(VIII) *[Newborn] Child of a dependent [or child of a dependent when paternity by the dependent is established after birth so long as the parent is a dependent on the newborn's date of birth or the date the child's paternity was established and continues to be covered as a dependent of the subscriber;] as long as the parent is a dependent on the child's date of birth. The dependent and his/her child must remain continuously covered on the plan from the dependent's child's date of birth for the child of the dependent to remain eligible;*

(IX) *[Child for whom the subscriber or spouse is required to provide coverage under a Qualified Medical Child Support Order (QMCSO); or] Child of a dependent when paternity by the dependent is established after birth as long as the parent is a dependent on the date the child's paternity was established. The dependent and his/her child must remain continuously covered on the plan from the dependent's child's paternity establishment date for the child of the dependent to remain eligible;*

(X) *[A child under twenty-six (26) years, who is a state employee, may be covered as a dependent of a state employee.] Child for whom the subscriber or spouse is required to provide coverage under a Qualified Medical Child Support Order (QMCSO); or*

(XI) *A child under twenty-six (26) years, who is a state employee, may be covered as a dependent of a state employee.*

B. A child who is twenty-six (26) years old or older and is permanently disabled in accordance with subsection (5)(G), may be

covered only if such child was disabled the day before the child turned twenty-six (26) years old and has remained continuously disabled.

C. A child may only be covered by one (1) parent if his/her parents are married to each other and are both covered under an MCHCP medical plan.

D. A child may have dual coverage if the child's parents are divorced or have never married, and both have coverage under an MCHCP medical plan. MCHCP will only pay for a service once, regardless of whether the claim for the child's care is filed under multiple subscribers' coverage. If a child has coverage under two (2) subscribers, the child will have a separate deductible, copayment, and coinsurance under each subscriber. The claims administrator will process the claim and apply applicable cost-sharing using the coverage of the subscriber who files the claim first. The second claim for the same services will not be covered. If a provider files a claim simultaneously under both subscribers' coverage, the claim will be processed under the subscriber whose birthday is first in the calendar year. If both subscribers have the same birthday, the claim will be processed under the subscriber whose coverage has been in effect for the longest period of time; or

3. Changes in dependent status. If a dependent loses his/her eligibility, the subscriber must notify MCHCP within thirty-one (31) days of the loss of eligibility. Coverage will end on the last day of the month that the completed form is received by MCHCP or the last day of the month MCHCP otherwise receives credible evidence of loss of eligibility under the plan.

(3) Enrollment Procedures.

(A) Active Employee Coverage.

1. Statewide Employee Benefit Enrollment System (SEBES). A new employee must enroll or waive coverage through SEBES at www.sebes.mo.gov or through another designated enrollment system within thirty-one (31) days of his/her hire date or the date the employer notifies the employee that s/he is an eligible variable-hour employee. If enrolling a spouse or child(ren), proof of eligibility must be submitted as defined in section (5).

2. An active employee may elect, change, or cancel coverage for the next plan year during the annual open enrollment period that runs October 1 through October 31 of each year.

3. An active employee may *[apply for]* **elect or change** coverage for himself/herself and/or for his/her spouse/child(ren) if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. An employee *[and]* or his/her spouse/child(ren) may enroll within sixty (60) days *[if s/he involuntarily loses]* **due to an involuntary loss of** employer-sponsored coverage under one (1) of the following circumstances:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends; or

C. If an active employee or his/her spouse/child(ren) loses MO HealthNet or Medicaid status, s/he may enroll in an MCHCP plan within sixty (60) days of the date of loss; or

D. If an active employee or active employee's spouse receives a court order stating s/he is responsible for covering a child, the active employee may enroll the child in an MCHCP plan within sixty (60) days of the court order.

4. Default enrollment.

[4./A. If an active employee is enrolled in the PPO 300 or

PPO 600 Plan and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the PPO *[600/ 1250]* Plan provided through the vendor the employee is enrolled in, effective the first day of the next calendar year.

[A./B. If an active employee is enrolled in the Health Savings Account (HSA) Plan *[(formerly High Deductible Health Plan)]* and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled in the HSA Plan at the same level of coverage.

[B./C. If an active employee is enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled in the TRICARE Supplemental Plan at the same level of coverage.

[C./D. Married state employees who are both MCHCP members who do not complete enrollment during the open enrollment period, will continue to meet one (1) family deductible and out-of-pocket maximum if they chose to do so during the previous plan year.

[5./E. If an active employee is enrolled in dental and/or vision coverage and does not complete open enrollment to cancel coverage or change the current level of coverage during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

[6./F. If an active employee submits an Open Enrollment Worksheet or an Enroll/Change/Cancel form that is incomplete or contains obvious errors, MCHCP will notify the employee of such by mail, phone, or secure message. The employee must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(B) Retiree Coverage.

1. To enroll or continue coverage for him/herself and his/her dependents or spouse/child(ren) at retirement, the employee must submit one (1) of the following:

A. A completed enrollment form within thirty-one (31) days of retirement date even if the retiree is continuing coverage as a variable-hour employee after retirement. Coverage is effective on retirement date; or

B. A completed enrollment form thirty-one (31) days before retirement date to have his/her first month's retirement premium deducted and divided between his/her last two (2) payrolls and the option to pre-pay premiums through the cafeteria plan; or

C. A completed enrollment form within thirty-one (31) days of retirement date with proof of prior medical, dental, or vision coverage under a group or individual insurance policy for six (6) months immediately prior to his/her retirement if s/he chooses to enroll in an MCHCP plan at retirement and has had insurance coverage for six (6) months immediately prior to his/her retirement.

2. A retiree may later add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A retiree may enroll his/her spouse/child(ren) within sixty (60) days *[if the spouse/child(ren) involuntarily loses]* **due to an involuntary loss of** employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

- (II) Eligibility for employer-sponsored coverage ends;
- (III) Employer contributions toward the premiums end; or
- (IV) COBRA coverage ends.

3. If coverage was not maintained while on disability, the employee may enroll him/herself and his/her spouse/child(ren) within thirty-one (31) days of the date the employee is eligible for retirement benefits subject to the eligibility provisions herein.

4. A retiree may change from one (1) medical plan to another during open enrollment, but cannot add coverage for a spouse/child(ren). If a retiree is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

5. *[If a retiree with Medicare is enrolled in the PPO 300 Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled at the same level of coverage in the PPO 300 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.]* **Default enrollment.**

[A. If a retiree with Medicare is enrolled in the PPO 600 Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled at the same level of coverage in the PPO 600 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.]

A. A retiree with Medicare and dependents with Medicare will be enrolled in the Medicare Advantage Plan.

(I) If the retiree or a dependent becomes Medicare eligible in January of the next calendar year, they will be enrolled in the Medicare Advantage Plan.

(II) If the retiree does not have Medicare Part B, and does not complete enrollment during the open enrollment period, the retiree and his/her dependents without Medicare will be enrolled in the PPO 1250 plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.

B. If a retiree with Medicare is enrolled in the PPO 300 or PPO 600 Plan and does not complete enrollment during the open enrollment period, and has dependents who are not covered by Medicare, his/her dependents without Medicare will be enrolled in the PPO 1250 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.

[B./C. If a retiree without Medicare is enrolled in the PPO 300 Plan or PPO 600 Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents without Medicare will be enrolled [at the same level of coverage] in the PPO [600] 1250 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.

[C./D. If a retiree without Medicare is enrolled in the HSA Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents without Medicare will be enrolled in the HSA Plan through the vendor the retiree is enrolled in at the same level of coverage, effective the first day of the next calendar year.

[(I) Retirees enrolled in the HSA Plan who become Medicare eligible or their dependents become Medicare eligible during the next plan year will be defaulted to the PPO 600 Plan effective the first day of the next calendar year, if they do not complete enrollment during the open enrollment period.]

[D./E. If a retiree without Medicare is currently enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled in the TRICARE Supplemental Plan at the same level of coverage, effective the first day of the next calendar year.

[E. If a retiree is enrolled in the Medicare Prescription Drug Only Plan and does not complete enrollment during the open enrollment period, the retiree and his/her Medicare eligible dependents will be enrolled in the Medicare Prescription

Drug Only Plan at the same level of coverage.]

6. If a retiree is enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

7. If a retiree submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Retiree Enrollment form that is incomplete or contains obvious errors, MCHCP will notify the retiree of such by mail, phone, or secure message. The retiree must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(C)/. Terminated Vested Coverage.

1. A terminated vested subscriber may later add a spouse/child(ren) to his/her coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A terminated vested subscriber may enroll his/her spouse/child(ren) within sixty (60) days *[if the spouse/child(ren) involuntarily loses]* due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

2. An enrolled terminated vested subscriber may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If an enrolled terminated vested subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

3. Default enrollment.

A. A terminated vested subscriber with Medicare and dependents with Medicare will be enrolled in the Medicare Advantage Plan.

(I) If the terminated vested subscriber or a dependent becomes Medicare eligible in January of the next calendar year, they will be enrolled in the Medicare Advantage Plan.

(II) If the terminated vested subscriber does not have Medicare Part B, and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents without Medicare will be enrolled in the PPO 1250 plan provided through the vendor the terminated vested subscriber is enrolled in, effective the first day of the next calendar year.

[3./B. If a terminated vested subscriber without Medicare is enrolled in the PPO 300 or PPO 600 Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents without Medicare will be enrolled [at the same level of coverage] in the PPO [600] 1250 Plan provided through the vendor the terminated vested subscriber is enrolled in, effective the first day of the next calendar year.

[A. If a terminated vested subscriber with Medicare is enrolled in the PPO 300 Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled at the same level of coverage in the PPO 300 Plan provided through the vendor the retiree is enrolled in, effective the first day of

the next calendar year.

B. If a terminated vested subscriber with Medicare is enrolled in the PPO 600 Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled at the same level of coverage in the PPO 600 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.

C. If a terminated vested subscriber **without Medicare** is enrolled in the HSA Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents **without Medicare** will be enrolled in the HSA Plan **through the vendor the terminated vested subscriber is enrolled in** effective the first day of the next calendar year, at the same level of coverage.

[(I) Terminated vested subscribers enrolled in the HSA Plan who become Medicare eligible during the next plan year will be defaulted to the PPO 600 Plan effective the first day of the next calendar year, if they do not complete enrollment during the open enrollment period.]

D. If a terminated vested subscriber **without Medicare** is enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled in the TRICARE Supplemental Plan effective the first day of the next calendar year, at the same level of coverage.

[4./E. If a terminated vested subscriber is enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

[5./4. If a terminated vested subscriber submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Terminated Vested Enrollment form that is incomplete or contains obvious errors, MCHCP will notify the terminated vested subscriber of such by mail, phone, or secure message. The terminated vested subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(D) Long-Term Disability Coverage.

1. A long-term disability subscriber may add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A long-term disability subscriber may enroll his/her spouse/child(ren) within sixty (60) days *[if the spouse/child(ren) involuntarily loses]* **due to an involuntary loss** of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

2. An enrolled long-term disability subscriber may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If an enrolled long-term disability subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

3. Default enrollment.

A. A long-term disability subscriber with Medicare and dependents with Medicare will be enrolled in the Medicare Advantage Plan.

(I) If the long-term disability subscriber or a dependent becomes Medicare eligible in January of the next calendar year, they will be enrolled in the Medicare Advantage Plan.

(II) If the long-term disability subscriber does not have Medicare Part B, and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents **without Medicare** will be enrolled in the PPO 1250 plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.

*[3./B. If a long-term disability subscriber without Medicare is enrolled in the PPO 300 or PPO 600 Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents **without Medicare** will be enrolled [at the same level of coverage] in the PPO [600] 1250 Plan provided through the vendor the long-term disability subscriber is enrolled in, effective the first day of the next calendar year.*

*[A./C. If a long-term disability subscriber with Medicare is enrolled in the PPO 300 or PPO 600 Plan and does not complete enrollment during the open enrollment period and has dependents who are not covered by Medicare, the long-term disability subscriber and his/her dependents **without Medicare** will be enrolled [at the same level of coverage] in the PPO [300] 1250 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.*

[B. If a long-term disability subscriber with Medicare is enrolled in the PPO 600 Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled at the same level of coverage in the PPO 600 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.]

*[C./D. If a long-term disability subscriber **without Medicare** is enrolled in the HSA Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents **without Medicare** will be enrolled in the HSA Plan **through the vendor the long-term disability subscriber is enrolled in** at the same level of coverage, effective the first day of the next calendar year.*

[(I) Long-term disability subscribers enrolled in the HSA Plan who become Medicare eligible during the next plan year will be defaulted to the PPO 600 Plan effective the first day of the next calendar year, if they do not complete enrollment during the open enrollment period.]

*[D./E. If a long-term disability subscriber **without Medicare** is enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents **without Medicare** will be enrolled in the TRICARE Supplemental Plan effective the first day of the next calendar year, at the same level of coverage.*

[4./F. If a long-term disability subscriber is enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

[5./4. If a long-term disability subscriber submits an Open Enrollment Worksheet or an Enroll/Change/Cancel form that is incomplete or contains obvious errors, MCHCP will notify the long-term disability subscriber of such by mail, phone, or secure message. The long-term disability subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(E) Survivor Coverage.

1. A survivor must submit a survivor enrollment form and a copy of the death certificate within thirty-one (31) days of the first

day of the month after the death of the employee.

A. If the survivor does not elect coverage within thirty-one (31) days of the first day of the month after the death of the employee, s/he cannot enroll at a later date.

B. If the survivor marries, has a child, adopts a child, or a child is placed with the survivor, the spouse/child(ren) must be added within thirty-one (31) days of birth, adoption, placement, or marriage.

C. If eligible spouse/child(ren) are not enrolled when first eligible, they cannot be enrolled at a later date.

2. A survivor may later add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A survivor may enroll his/her spouse/child(ren) within sixty (60) days *[if the spouse/child(ren) involuntarily loses]* due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

3. A survivor may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If a survivor is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

4. Default enrollment.

A. A survivor with Medicare and dependents with Medicare will be enrolled in the Medicare Advantage Plan.

(I) If the survivor or a dependent becomes Medicare eligible in January of the next calendar year, they will be enrolled in the Medicare Advantage Plan.

(II) If the survivor does not have Medicare Part B, and does not complete enrollment during the open enrollment period, the survivor and his/her dependents without Medicare will be enrolled in the PPO 1250 plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.

[4./B. If a survivor without Medicare is enrolled in the PPO 300 or PPO 600 Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents without Medicare will be enrolled [at the same level of coverage] in the PPO [600] 1250 Plan provided through the vendor the survivor is enrolled in, effective the first day of the next calendar year.

[A./C. If a survivor with Medicare is enrolled in the PPO 300 or PPO 600 Plan and does not complete enrollment during the open enrollment period and has dependents who are not covered by Medicare, the survivor and his/her dependents without Medicare will be enrolled [at the same level of coverage] in the PPO [300] 1250 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.

[B. If a survivor with Medicare is enrolled in the PPO 600 Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents will be enrolled at the same level of coverage in the PPO 600 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year.]

[C./D. If a survivor without Medicare is enrolled in the HSA Plan and does not complete enrollment during the open enrollment

period, the survivor and his/her dependents without Medicare will be enrolled in the HSA Plan through the vendor the survivor is enrolled in at the same level of coverage, effective the first day of the next calendar year.

[(I) Survivors who are enrolled in the HSA Plan who become Medicare eligible during the next plan year will be defaulted to the PPO 600 Plan effective the first day of the next calendar year, if they do not complete enrollment during the open enrollment period.]

[D./E. If a survivor without Medicare is enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents without Medicare will be enrolled in the TRICARE Supplemental Plan effective the first day of the next calendar year, at the same level of coverage.

[5./F. If a survivor is enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the survivor and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

[6./J. If a survivor submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Survivor Enrollment form that is incomplete or contains obvious errors, MCHCP will notify the survivor of such by mail, phone, or secure message. The survivor must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(5) Proof of Eligibility. Proof of eligibility documentation is required for all dependents and subscribers, as necessary. Enrollment is not complete until proof of eligibility is received by MCHCP. A subscriber must include his/her MCHCPid or Social Security number on the documentation. If proof of eligibility is not received, MCHCP will send a letter requesting it from the subscriber. Except for open enrollment, documentation must be received within thirty-one (31) days of the date MCHCP processed the enrollment, or coverage will not take effect for those individuals whose proof of eligibility was not received. MCHCP reserves the right to request that such proof of eligibility be provided at any time upon request. If such proof is not received or is unacceptable as determined by MCHCP, coverage will terminate or never take effect. If enrolling during open enrollment, proof of eligibility must be received by November 20, or coverage will not take effect the following January 1 for those individuals whose proof of eligibility was not received. If invalid proof of eligibility is received, the subscriber is allowed an additional ten (10) days from the initial due date to submit valid proof of eligibility.

(A) When enrolling a newborn child, the *[member]* subscriber must notify MCHCP of the birth verbally or in writing within thirty-one (31) days of the birth date. MCHCP will then send an enrollment form and letter notifying the *[member]* subscriber of the steps to initiate coverage. The *[member]* subscriber is allowed an additional ten (10) days from the date of the plan notice to return the enrollment form. Coverage will not begin unless the enrollment form is received within thirty-one (31) days of the birth date or ten (10) days from the date of the notice, whichever is later. Newborn proof of eligibility must be submitted within ninety (90) days of the birth date. If proof of eligibility is not received, coverage will terminate on day ninety-one (91) from the birth date.

(G) Disabled Dependent.

1. A new employee may enroll his/her permanently disabled child or an enrolled permanently disabled dependent turning age twenty-six (26) years and may continue coverage beyond age twenty-six (26) years, provided the following documentation is submitted to the plan prior to the end of the month of the dependent's twenty-sixth birthday for the enrolled permanently disabled dependent or within thirty-one (31) days of enrollment of a new employee and his/her permanently disabled child:

A. Evidence from the Social Security Administration (SSA)

that the permanently disabled dependent or child was entitled to and receiving disability benefits prior to turning age twenty-six (26) years; and

B. A benefit verification letter dated within the last twelve (12) months from the SSA confirming the child is still considered disabled.

2. If a disabled dependent or child over the age of twenty-six (26) years is determined to be no longer disabled by the SSA, coverage will terminate the last day of the month in which the disability ends or will never take effect for new enrollment requests.

3. Once the disabled dependent's coverage is cancelled or terminated, s/he will not be able to enroll at a later date.

(8) Voluntary Cancellation of Coverage.

(D) A subscriber may only cancel dental and/or vision coverage during the year for him/herself or his/her dependents for one (1) of the following reasons:

1. Upon retirement;
2. When beginning a leave of absence;
3. No longer eligible for coverage; *[or]*
4. When new coverage is taken through other employment~~./~~; **or**
5. **When the member enrolls in Medicaid.**

(9) Continuation of Coverage.

(A) Leave of Absence.

1. An employee on an approved leave of absence may continue participation in the plan by paying the required contributions. The employing department must officially notify MCHCP of the leave of absence and any extension of the leave of absence by submitting the required form through eMCHCP. The employee will receive a letter, Leave of Absence Enrollment form, and bill (if applicable) from MCHCP to continue coverage. If the completed form and payment (if applicable) are returned within *[ten (10)] fourteen (14)* days of the date of the letter, coverage will continue. The employee will be set up on direct bill unless the employee and affected dependents are transferred to the plan in which his/her spouse is enrolled.

2. If the employee does not elect to continue coverage, coverage for the employee and his/her dependents is terminated effective the last day of the month in which the employee is employed.

3. If the employee's spouse is an active employee or retiree, the employee and any dependents may transfer to the plan in which the spouse is enrolled if the transfer is elected on the Leave of Absence Enrollment form. Transfer is effective the first of the month following the date of leave. If the employee wishes to be covered individually at a later date, s/he can make the change as long as coverage is continuous. When the employee returns to work, s/he and his/her spouse must be covered individually.

4. Any employee on an approved leave of absence who was a member of MCHCP when the approved leave began, but who subsequently terminated coverage with MCHCP while on leave, may reenroll in his/her coverage in the plan at the same level (employee only or employee and dependents) upon returning to employment directly from the leave or if the employee was on leave of absence during open enrollment or while on leave of absence leave had a qualifying life event or loss of employer-sponsored coverage, the employee may change plans and add spouse/child(ren). When a leave of absence employee returns to work and MCHCP receives a state contribution for the month s/he returned, s/he will be charged the applicable active employee premium for that month. For coverage to be reinstated, the employee must submit a completed Enroll/Change/Cancel form within thirty-one (31) days of returning to work. Coverage is reinstated on the first of the month coinciding with or after the date the form is received. Coverage will be continuous if the employee returns to work in the subsequent month following the initial leave date.

5. If the employee chooses to maintain employee coverage but not coverage for his/her dependents, the employee is eligible to regain dependent coverage upon return to work.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Amended: Filed Oct. 31, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

PROPOSED AMENDMENT

22 CSR 10-2.030 Contributions. The Missouri Consolidated Health Care Plan is amending sections (6) and (7).

PURPOSE: This amendment revises the Missouri Consolidated Health Care Plan contribution methodology for retiree coverage; removes language related to the Medicare Prescription Drug Only Plan; and renumbers as necessary.

(6) The Missouri Consolidated Health Care Plan (MCHCP) contribution toward retiree coverage is based on either of the following:

(A) *[It] The contribution percentage* is calculated by using the number of full creditable years of service at retirement as reported to MCHCP by Missouri State Employees' Retirement System (MOSERS) or Public School Retirement System (PSRS) multiplied by two and one half percent (2.5%). The resulting product shall be capped at sixty-five percent (65%), or in other words the retiree's years of service is capped at twenty-six (26) years. *[For Medicare retirees, the computed percentage is multiplied by the retiree only PPO 600 Plan total premium. For non-Medicare retirees, the computed percentage is multiplied by the retiree only PPO 600 Plan total premium with the tobacco-free incentive and the partnership incentive. The resulting product is the MCHCP contribution, which shall be subtracted from the total premium of the plan chosen by the retiree. The difference is the amount of the retiree contribution toward the total premium. In addition, for Medicare retirees covering dependents, MCHCP will contribute for the dependent portion of the premium the lesser of the following: two and one half percent (2.5%) multiplied by the number of full creditable years of service at retirement (capped at twenty-six (26) years) multiplied by the difference in premium of the retiree only PPO 600 Plan and the premium of the PPO 600 Plan at the rate tier the retiree has selected or the dollar amount MCHCP contributes for the dependent portion of the PPO 600 premium for an active employee at the rate tier the retiree has selected. For non-Medicare retirees, MCHCP will contribute for the dependent portion of the premium the lesser of the following: two and one half percent (2.5%)*

multiplied by the number of full creditable years of service at retirement (capped at twenty-six (26) years) multiplied by the difference in premium of the retiree only PPO 600 Plan total premium with tobacco-free incentive and partnership incentive and the premium of the PPO 600 Plan at the rate tier the retiree has selected or the dollar amount the MCHCP contributes for the dependent portion of the PPO 600 premium for an active employee at the rate tier the retiree has selected. The above calculations can be written by formula as follows:]

[1. Medicare Retiree MCHCP contribution = (2.5% x full creditable years of service (up to 26 years) x Retiree only PPO 600 Plan total premium) + Medicare Retiree MCHCP dependent contribution (if any);

2. Non-Medicare Retiree MCHCP contribution = 2.5% x full creditable years of service (up to 26 years) x Retiree only PPO 600 Plan total premium with tobacco-free incentive and the partnership incentive + Non-Medicare Retiree MCHCP dependent contribution (if any);

3. Medicare Retiree MCHCP dependent contribution = lesser of (2.5% x full creditable years of service (up to 26 years) x (PPO 600 Plan total premium at the rate tier the retiree has selected – Retiree only PPO 600 Plan total premium)) or the dollar amount MCHCP contributes for the dependent portion of the PPO 600 premium for an active employee at the rate tier the retiree has selected; or

4. Non-Medicare Retiree MCHCP dependent contribution = lesser of (2.5% x full creditable years of service (up to 26 years) x (PPO 600 Plan total premium with tobacco-free incentive and partnership incentive at the rate tier the retiree has selected – Retiree only PPO 600 Plan total premium with tobacco-free incentive and partnership incentive)) or the dollar amount MCHCP contributes for the dependent portion of the PPO 600 premium for an active employee at the rate tier the retiree has selected;]

1. Medicare retirees.

A. For Medicare retirees, the contribution percentage is multiplied by the retiree only Medicare Advantage Plan total premium. The resulting product is the MCHCP contribution, which shall be subtracted from the Medicare Advantage total premium. The difference is the amount of the retiree contribution toward the total premium.

B. For Medicare retirees covering Medicare-eligible dependents, MCHCP will contribute for the dependent portion of the premium the lesser of the following: the contribution percentage multiplied by the Medicare Advantage premium, or the dollar amount MCHCP contributes for the dependent portion of the PPO 1250 premium for an active employee at the rate tier the retiree has selected.

C. For Medicare retirees covering non-Medicare eligible dependents, MCHCP will contribute for the dependent portion of the premium the lesser of the following: the contribution percentage multiplied by the difference in premium of the retiree only Medicare Advantage Plan and the premium of the dependent portion of the PPO 1250 Plan at the rate tier the retiree has selected, or the dollar amount MCHCP contributes for the dependent portion of the PPO 1250 premium for an active employee at the rate tier the retiree has selected.

2. Non-Medicare retirees.

A. For non-Medicare retirees, the contribution percentage is multiplied by the retiree only PPO 1250 Plan total premium with the tobacco-free incentive and the partnership incentive. The resulting product is the MCHCP contribution, which shall be subtracted from the total premium of the plan chosen by the retiree. The difference is the amount of the retiree contribution toward the total premium.

B. For non-Medicare retirees covering Medicare-eligible dependents, MCHCP will contribute for the dependent portion of the premium the lesser of the following: the contribution per-

centage multiplied by the Medicare Advantage premium, or the dollar amount MCHCP contributes for the dependent portion of the PPO 1250 premium for an active employee at the rate tier the retiree has selected.

C. For non-Medicare retirees covering non-Medicare eligible dependents, MCHCP will contribute for the dependent portion of the premium the lesser of the following: contribution percentage multiplied by the difference in premium of the retiree only PPO 1250 Plan total premium with tobacco-free incentive and partnership incentive and the premium of the PPO 1250 Plan at the rate tier the retiree has selected, or the dollar amount MCHCP contributes for the dependent portion of the PPO 1250 premium for an active employee at the rate tier the retiree has selected.

(B) For those retiring prior to July 1, 2002, the amount calculated in subsection [(3)](6)(A) is compared to the flat dollar amount that was contributed for the same rate tier in 2002. The retiree's subsidy is the greater of the amount calculated in subsection [(3)](6)(A) or the flat dollar amount that was contributed in 2002.

[(7) The Missouri Consolidated Health Care Plan (MCHCP) contribution toward the retiree and survivor premium for members enrolled in the Medicare Prescription Drug Only Plan is based on either of the following:

(A) The subsidy is calculated by using the number of full creditable years of service at retirement as reported to MCHCP by MOSERS or PSRS multiplied by two and one half percent (2.5%), and capped at sixty-five percent (65%). The computed percentage is multiplied by the Medicare Prescription Drug Only Plan premium at the rate tier the retiree selected. The resulting product is the MCHCP contribution, which shall be subtracted from the total Medicare Prescription Drug Only Plan premium. The difference is the amount of the retiree contribution toward the Medicare Prescription Drug Only Plan premium. The above calculation can be written by formula as follows: Retiree MCHCP contribution = 2.5% x full creditable years of service (up to 26 years) x Medicare Prescription Drug Only Plan premium; or

(B) For those retiring prior to July 1, 2002, the amount calculated in subsection (7)(A) is compared to fifty-nine percent (59%) of the total premium for the Medicare Prescription Drug Only Plan. The retiree's subsidy is the greater of the amount calculated in subsection (7)(A) or fifty-nine percent (59%) of the Medicare Prescription Drug Only Plan.]

[(8)](7) Premium. Payroll deductions, Automated Clearing House (ACH) transactions, debit cards, credit cards, and/or direct bills are processed by MCHCP.

(A) Active Employee Whose Payroll Information is Housed in the SAM II Human Resource System.

1. Monthly medical premium payroll deductions are divided in half and taken by MCHCP at the end of the prior month and the fifteenth of the current month for the current month's coverage (example: September 30 and October 15 payroll deductions are taken for October medical premiums).

2. Monthly dental and vision premium payroll deductions are divided in half and taken by MCHCP on the fifteenth of the current month and the end of the current month for the current month's dental and vision coverage (example: October 15 and October 31 payroll deductions are taken for October dental and vision premiums).

3. If a subscriber owes premiums outside the current month, payroll deductions for all other premiums owed will be divided equally and taken from the subscriber's future payrolls as follows:

A. Fifty dollars (\$50) or less, deduction will be taken from one (1) payroll;

B. Fifty-one dollars (\$51) to one hundred dollars (\$100) will be deducted from two (2) payrolls;

C. One hundred one dollars (\$101) to two hundred dollars

(\$200) will be deducted from three (3) payrolls;

D. Two hundred one dollars (\$201) to three hundred dollars (\$300) will be deducted from four (4) payrolls;

E. Three hundred one dollars (\$301) to four hundred dollars (\$400) will be deducted from five (5) payrolls;

F. Four hundred one dollars (\$401) to five hundred dollars (\$500) will be deducted from six (6) payrolls;

G. Five hundred one dollars (\$501) to six hundred dollars (\$600) will be deducted from seven (7) payrolls;

H. Six hundred one dollars (\$601) to seven hundred dollars (\$700) will be deducted from eight (8) payrolls;

I. Seven hundred one dollars (\$701) to eight hundred dollars (\$800) will be deducted from nine (9) payrolls;

J. Eight hundred one dollars (\$801) to nine hundred dollars (\$900) will be deducted from ten (10) payrolls;

K. Nine hundred one dollars (\$901) to one thousand dollars (\$1,000) will be deducted from eleven (11) payrolls; and

L. One thousand one dollars (\$1,001) and over will be deducted from twelve (12) payrolls.

4. If the active employee's check is not sufficient to cover his/her premium, the active employee will receive a monthly bill for the premium.

(B) Active Employee Whose Payroll Information is not Housed in the SAM II Human Resource System.

1. Premium payroll deductions are submitted to MCHCP monthly from the agency based on the deductions taken from the employee's payroll.

A. Medical premium payroll deduction received at the end of the month is applied to the employee's next month's coverage (example: September 30 payroll deduction is taken for the October medical premium).

B. Dental and vision premium payroll deductions received at the end of the month are applied to the current month's dental and vision coverage (example: September 30 payroll deductions are taken for September dental and vision premiums).

C. If a subscriber owes past-due premiums, payroll deductions for current premiums along with the payroll deductions for past-due premiums may be taken at the discretion of the employer.

2. If the active employee's check is not sufficient to cover his/her premium, the active employee will receive a monthly bill for the premium.

(C) Retirees and Survivors Premiums From Benefit Check.

1. Deduction amounts are received monthly from MOSERS based on the deductions taken from the benefit checks. Medical, dental, and vision deductions received at the end of the month pay for the next month's coverage (example: September 30 benefit check deduction is taken for October medical, dental, and vision premiums).

2. If a retiree or survivor is currently having deductions taken from his/her benefit check and owes past-due premiums due to a change in his/her deductions, MCHCP will contact MOSERS to determine if the benefit check is large enough to cover the past-due premiums. If the benefit check is large enough to cover the past-due premiums, deductions will be divided and taken from the retiree or survivor's next three (3) benefit checks and coverage will be continuous. If the retiree or survivor's benefit check is not large enough to cover the deductions, and the retiree or survivor has failed to make the necessary premium payments, coverage will be terminated due to nonpayment, effective the last day of the month a full premium was received.

(D) Direct Bill of Premium Owed By Subscribers Whose Premium is not Deducted from Payroll or Benefit Check.

1. Premiums are billed on the last working day of the month for the next month's coverage. Premiums are due fifteen (15) days from the last day of the month in which they are billed (example: bill mailed September 30 for October medical, dental, and vision premiums, premium due October 15).

2. A subscriber may elect to pay premiums by ACH electronic payment. In that case, the subscriber agrees that he/she will not

receive a monthly bill.

A. Premiums are deducted from a subscriber's bank account on the fifth of the month to pay for the current month's coverage (example: October 5 deduction taken for October medical, dental, and vision premiums).

B. If there are insufficient funds, MCHCP will bill the subscriber for the premium owed. The due date of the premium owed shall not change due to insufficient funds.

[(9)](8) Premium Payments.

(A) By enrolling in coverage under MCHCP, an active employee agrees that MCHCP may deduct the member's contribution toward the total premium from the subscriber's paycheck. Payment for the first month's premium is made by payroll deduction. Subsequent premium payments are deducted from the active employee's paycheck. If the active employee's check is not sufficient to cover his/her premium, the active employee agrees to pay MCHCP by check, money order, ACH or cash, or by any other monetary transaction supported by MCHCP.

(B) By enrolling in coverage under MCHCP, the retiree or survivor agrees that MCHCP will automatically deduct the premium from the retiree or survivor's benefit check. The retiree or survivor may choose to receive a monthly bill in lieu of an automatic deduction. If the retiree or survivor's deduction is not sufficient to cover his/her premium or the retiree or subscriber chooses to receive a monthly bill, the retiree or survivor agrees to pay MCHCP by check, money order, ACH or cash, or by any other monetary transaction supported by MCHCP.

(C) If the subscriber fails to make the necessary premium payments, coverage terminates on the last day of the month for which full premium payment was received. The subscriber is responsible for claims submitted after the termination date.

1. If a non-Medicare subscriber fails to pay premiums by the required due date, MCHCP allows a thirty-one- (31-) day grace period from the due date. In the event that MCHCP has not received payment of premium at the end of the thirty-one- (31-) day grace period, coverage will be retroactively terminated on the last day of the month for which full premium payment was received. The subscriber will be responsible for the value of the services rendered after the retroactive termination date, including, but not limited to, the grace period.

2. If a Medicare primary subscriber fails to pay premiums by the required due date, MCHCP allows a sixty- (60-) day grace period from the due date. In the event that MCHCP has not received payment of premium at the end of the sixty- (60-) day grace period, coverage will be terminated effective the end of month in which the sixty- (60-) day grace period ends.

[(10)](9) Refunds of overpayments are limited to the amount overpaid during the twelve- (12-) month period ending at the end of the month preceding the month during which notice of overpayment is received by MCHCP.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Amended: Filed Oct. 31, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in

support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

PROPOSED AMENDMENT

22 CSR 10-2.045 Plan Utilization Review Policy. The Missouri Consolidated Health Care Plan amending section (1).

PURPOSE: *This amendment adds preauthorization requirements for chemotherapy for cancer diagnosis, dialysis, and specialty injectables; revises preauthorization requirements for surgery (outpatient); alphabetizes the list of medical services, and renumbers as necessary.*

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program has the following components:

(A) Preauthorization—The claims administrator must authorize some services in advance. Without preauthorization, any claim that requires preauthorization will be denied for payment. Members who have another primary carrier, *[including,]* **or who are enrolled in the Medicare[,]** **Advantage Plan** are not subject to this provision except for those services that are not covered by the other primary carrier, but are otherwise subject to preauthorization under this rule. Preauthorization does not verify eligibility or payment. Preauthorizations found to have a material misrepresentation or intentional or negligent omission about the person's health condition or the cause of the condition may be rescinded.

1. The following medical services are subject to preauthorization:

A. Ambulance services for non-emergent use, whether air or ground;

B. Anesthesia and hospital charges for dental care for children younger than five (5) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization;

C. Applied behavior analysis for autism at initial service;

D. Auditory brainstem implant (ABI);

E. Bariatric surgery;

F. Cardiac rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;

G. Chelation therapy;

H. Chemotherapy for cancer diagnosis;

[G./I.] Chiropractic services after twenty-six (26) visits annually;

[H./J.] Cochlear implant device;

[I.] Chelation therapy;]

[J./K.] Dental care;

L. Dialysis

[K./M.] Durable medical equipment (DME) over one thousand five hundred dollars (\$1,500) or DME rentals over five hundred dollars (\$500) per month;

[L./N.] Genetic testing or counseling;

[M./O.] Hearing Aids;

[N./P.] Home health care;

[O./Q.] Hospice care and palliative services;

[P./R.] Hospital inpatient services;

[Q./S.] Imaging (diagnostic non-emergent outpatient), including magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positron emission tomography (PET), computerized tomography scan (CT), computerized tomography angiography

(CTA), electron-beam computed tomography (EBCT), and nuclear cardiology;

[R./T.] Maternity coverage for maternity hospital stays longer than forty-eight (48) hours for vaginal delivery or ninety-six (96) hours for cesarean delivery;

[S./U.] Nutritional counseling after six (6) sessions annually;

[T./V.] Orthognathic surgery;

[U./W.] Orthotics over one thousand dollars (\$1,000);

[V./X.] Physical, speech, and occupational therapy and rehabilitation services (outpatient) after sixty (60) combined visits per calendar year;

[W./Y.] Procedures with procedure codes ending in "T" (temporary procedure codes used for data collection, experimental, investigational, or unproven procedures);

[X./Z.] Prostheses over one thousand dollars (\$1,000);

[Y./AA.] Pulmonary rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;

[Z./BB.] Skilled nursing facility;

CC. Specialty injectables;

[AA./DD.] Surgery (outpatient)—The following outpatient surgical procedures: cornea transplant, potential cosmetic surgery, sleep apnea surgery, implantable stimulators, stimulators for bone growth, spinal surgery (including, but not limited to, artificial disc replacement, fusions, nonpulsed radiofrequency denervation, vertebroplasty, kyphoplasty, spinal cord stimulator trials, spinal cord stimulator implantation, and any unlisted spinal procedure), **total hip arthroplasty, total knee arthroplasty**, and oral surgery (excisions of tumors and cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological exams); and

[BB./EE.] Transplants, including requests related to covered travel and lodging.

2. The following pharmacy services included in the prescription drug plan for non-Medicare primary members are subject to preauthorization:

A. Second-step therapy medications that skip the first-step medication trial;

B. Specialty medications;

C. Medications that may be prescribed for several conditions, including some for which treatment is not medically necessary;

D. Medication refill requests that are before the time allowed for refill;

E. Medications that exceed drug quantity and day supply limitations; and

F. Medications with costs exceeding nine thousand nine hundred ninety-nine dollars and ninety-nine cents (\$9,999.99) at retail or the mail order pharmacy and one hundred forty-nine dollars and ninety-nine cents (\$149.99) for compound medications at retail or the mail order pharmacy.

3. Preauthorization timeframes.

A. A benefit determination for non-urgent preauthorization requests will be made within fifteen (15) calendar days of the receipt of the request. The fifteen (15) days may be extended by the claims administrator for up to fifteen (15) calendar days if an extension is needed as a result of matters beyond the claims administrator's control. The claims administrator will notify the member of any necessary extension prior to the expiration of the initial fifteen- (15-) calendar-day period. If a member fails to submit necessary information to make a benefit determination, the member will be given at least ninety (90) calendar days from receipt of the extension notice to respond with additional information.

B. A benefit determination for urgent preauthorization requests will be made as soon as possible based on the clinical situation, but in no case later than twenty-four (24) hours of the receipt of the request;

AUTHORITY: *section 103.059, RSMo [2000] 2016. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the Code of State Regulations.*

Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Amended: Filed Oct. 31, 2018.

PUBLIC COST: *This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

PRIVATE COST: *This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

NOTICE TO SUBMIT COMMENTS: *Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

PROPOSED RULE

22 CSR 10-2.046 PPO 750 Plan Benefit Provisions and Covered Charges

PURPOSE: *This rule establishes the policy of the board of trustees in regard to the PPO 750 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.*

(1) Deductible—per calendar year for network: per individual, seven hundred fifty dollars (\$750); family, one thousand five hundred dollars (\$1,500) and for non-network: per individual, one thousand five hundred dollars (\$1,500); family, three thousand dollars (\$3,000).

(A) Network and non-network deductibles are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Claims will not be paid until the applicable deductible is met.

(C) Services that do not apply to the deductible and for which applicable costs will continue to be charged include, but are not limited to: copayments, charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(D) The family deductible is an embedded deductible with two (2) parts: an individual deductible and an overall family deductible. Each family member must meet his/her own individual deductible amount until the overall family deductible amount is reached. Once a family member meets his/her own individual deductible, the plan will start to pay claims for that individual and any additional out-of-pocket expenses incurred by that individual will not be used to meet the family deductible amount. Once the overall family deductible is met, the plan will start to pay claims for the entire family even if some family members have not met his/her own individual deductible.

(2) Coinsurance—Coinsurance amounts apply to covered services after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(A) Network claims are paid at eighty percent (80%) until the out-of-pocket maximum is met.

(B) Non-network claims are paid at sixty percent (60%) until the out-of-pocket maximum is met.

(3) Out-of-pocket maximum—per calendar year for network: per individual, two thousand two hundred fifty dollars (\$2,250); family, four thousand five hundred dollars (\$4,500) and for non-network:

per individual, four thousand five hundred dollars (\$4,500); family, nine thousand dollars (\$9,000).

(A) Network and non-network out-of-pocket maximums are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include, but are not limited to: charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(C) The family out-of-pocket maximum is an embedded out-of-pocket maximum with two (2) parts: an individual out-of-pocket maximum and an overall family out-of-pocket maximum. Each family member must meet his/her own individual out-of-pocket maximum amount until the overall family out-of-pocket maximum amount is reached. Once a family member meets his/her own individual out-of-pocket maximum, the plan will start to pay claims at one hundred percent (100%) for that individual. Once the overall family out-of-pocket maximum is met, the plan will start to pay claims at one hundred percent (100%) for the entire family even if some family members had not met his/her own individual out-of-pocket maximum.

(4) The following services will be paid as a network benefit when provided by a non-network provider:

(A) Emergency services and urgent care;

(B) Covered services that are not available through a network provider within one hundred (100) miles of the member's home. The member must contact the claims administrator before the date of service in order to have a closer non-network provider's claims approved as a network benefit. Such approval is for three (3) months. After three (3) months, the member must contact the claims administrator to reassess network availability;

(C) Covered services when such services are provided in a network hospital or ambulatory surgical center and are an adjunct to a service being performed by a network provider. Examples of such adjunct services include, but are not limited to, anesthesiology, assistant surgeon, pathology, or radiology.

(5) The following services are not subject to deductible, coinsurance, or copayment requirements and will be paid at one hundred percent (100%) when provided by a network provider:

(A) Preventive care;

(B) Nutrition counseling;

(C) A newborn's initial hospitalization until discharge or transfer to another facility if the mother is a Missouri Consolidated Health Care Plan (MCHCP) member at the time of birth; and

(D) Four (4) Diabetes Self-Management Education/Training visits with a certified diabetes educator when ordered by a provider.

(6) Influenza vaccinations provided by a non-network provider will be reimbursed up to twenty-five dollars (\$25) once the member submits a receipt and a reimbursement form to the claims administrator.

(7) Married, active employees who are MCHCP subscribers and have enrolled children may meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must provide the other spouse's Social Security number (SSN) and report the other spouse as eligible for coverage when newly hired and during the open enrollment process. In the medical plan vendor and pharmacy benefit manager system, the spouse with children enrolled will be considered the subscriber and the spouse that does not have children enrolled will be considered a dependent. If both spouses have children enrolled the spouse with the higher Social Security number (SSN) will be considered the subscriber. Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

(8) Each subscriber will have access to payment information of the family unit only when authorization is granted by the adult covered dependent(s).

(9) Expenses toward the deductible and out-of-pocket maximum will be transferred if the member changes non-Medicare medical plans during the plan year or continues enrollment under another subscriber's non-Medicare medical plan within the same plan year.

(10) Copayments.

(A) Emergency room—two hundred fifty dollars (\$250) network and non-network. Deductible and coinsurance requirements apply to emergency room services in addition to the copayment. If a member is admitted to the hospital or the claims administrator considers the claim to be for a true emergency, the copayment is waived.

(B) Inpatient hospitalization—two hundred dollars (\$200) per admission for network and non-network. Deductible and coinsurance requirements apply to inpatient hospitalization services in addition to the copayment.

(11) Maximum plan payment—non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed at one hundred ten percent (110%) of Medicare reimbursement. Members may be held liable for the amount of the fee above the allowed amount.

(12) Any claim must be initially submitted within twelve (12) months following the date of service. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

(13) For a member who is an inpatient on the last calendar day of a plan year and remains an inpatient into the next plan year, the prior plan year's applicable copayment, deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

(14) Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-2.055. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as a non-network benefit. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

(15) Medicare.

(A) When MCHCP becomes aware that the member is eligible for Medicare benefits, claims will be processed reflecting Medicare coverage.

(B) If a member does not enroll in Medicare when s/he is eligible and Medicare should be the member's primary plan, the member will be responsible for paying the portion Medicare would have paid. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

(C) If a Medicare primary member chooses a provider who has opted out of Medicare, the member will be responsible for paying the portion Medicare would have paid if the service was performed by a Medicare provider. An estimate of Medicare Part A and/or Part B

benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Original rule filed Oct. 31, 2018.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN

Division 10—Health Care Plan

Chapter 2—State Membership

PROPOSED RULE

22 CSR 10-2.047 PPO 1250 Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 1250 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

(1) Deductible—per calendar year for network: per individual, one thousand two hundred fifty dollars (\$1,250); family, two thousand five hundred dollars (\$2,500) and for non-network: per individual, two thousand five hundred dollars (\$2,500); family, five thousand dollars (\$5,000).

(A) Network and non-network deductibles are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Claims will not be paid until the applicable deductible is met.

(C) Services that do not apply to the deductible and for which applicable costs will continue to be charged include, but are not limited to: copayments, charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(D) The family deductible is an embedded deductible with two (2) parts: an individual deductible and an overall family deductible. Each family member must meet his/her own individual deductible amount until the overall family deductible amount is reached. Once a family member meets his/her own individual deductible, the plan will start to pay claims for that individual and any additional out-of-pocket expenses incurred by that individual will not be used to meet the family deductible amount. Once the overall family deductible is met, the plan will start to pay claims for the entire family even if some family members have not met his/her own individual deductible.

(2) Coinsurance—coinsurance amounts apply to covered services after deductible has been met. Coinsurance is no longer applicable

for the remainder of the calendar year once the out-of-pocket maximum is reached.

(A) Network claims are paid at eighty percent (80%) until the out-of-pocket maximum is met.

(B) Non-network claims are paid at sixty percent (60%) until the out-of-pocket maximum is met.

(3) Out-of-pocket maximum—per calendar year for network: per individual, three thousand seven hundred fifty dollars (\$3,750); family, seven thousand five hundred dollars (\$7,500) and for non-network: per individual, seven thousand five hundred dollars (\$7,500); family, fifteen thousand dollars (\$15,000).

(A) Network and non-network out-of-pocket maximums are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include, but are not limited to: charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(C) The family out-of-pocket maximum is an embedded out-of-pocket maximum with two (2) parts: an individual out-of-pocket maximum and an overall family out-of-pocket maximum. Each family member must meet his/her own individual out-of-pocket maximum amount until the overall family out-of-pocket maximum amount is reached. Once a family member meets his/her own individual out-of-pocket maximum, the plan will start to pay claims at one hundred percent (100%) for that individual. Once the overall family out-of-pocket maximum is met, the plan will start to pay claims at one hundred percent (100%) for the entire family even if some family members had not met his/her own individual out-of-pocket maximum.

(4) The following services will be paid as a network benefit when provided by a non-network provider:

(A) Emergency services and urgent care;

(B) Covered services that are not available through a network provider within one hundred (100) miles of the member's home. The member must contact the claims administrator before the date of service in order to have a closer non-network provider's claims approved as a network benefit. Such approval is for three (3) months. After three (3) months, the member must contact the claims administrator to reassess network availability; and

(C) Covered services when such services are provided in a network hospital or ambulatory surgical center and are an adjunct to a service being performed by a network provider. Examples of such adjunct services include, but are not limited to, anesthesiology, assistant surgeon, pathology, or radiology.

(5) The following services are not subject to deductible, coinsurance, or copayment requirements and will be paid at one hundred percent (100%) when provided by a network provider:

(A) Preventive care;

(B) Nutrition counseling;

(C) A newborn's initial hospitalization until discharge or transfer to another facility if the mother is a Missouri Consolidated Health Care Plan (MCHCP) member at the time of birth; and

(D) Four (4) Diabetes Self-Management Education/Training visits with a certified diabetes educator when ordered by a provider.

(6) Influenza vaccinations provided by a non-network provider will be reimbursed up to twenty-five dollars (\$25) once the member submits a receipt and a reimbursement form to the claims administrator.

(7) Married, active employees who are MCHCP subscribers and have enrolled children may meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must provide the other spouse's Social Security number (SSN) and report the other spouse as eligible for coverage when newly hired and during the open

enrollment process. In the medical plan vendor and pharmacy benefit manager systems, the spouse with children enrolled will be considered the subscriber and the spouse that does not have children enrolled will be considered a dependent. If both spouses have children enrolled, the spouse with the higher Social Security number (SSN) will be considered the subscriber. Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

(8) Each subscriber will have access to payment information of the family unit only when authorization is granted by the adult covered dependent(s).

(9) Expenses toward the deductible and out-of-pocket maximum will be transferred if the member changes non-Medicare medical plans or continues enrollment under another subscriber's non-Medicare medical plan within the same plan year.

(10) Copayments. Copayments apply to network services unless otherwise specified.

(A) Office visit—primary care: twenty-five dollars (\$25); mental health: twenty-five dollars (\$25); specialist: forty dollars (\$40); chiropractor office visit and/or manipulation: the lesser of twenty dollars (\$20) or fifty percent (50%) of the total cost of services; urgent care: fifty dollars (\$50) network and non-network. All lab, X-ray, or other medical services associated with the office visit apply to the deductible and coinsurance.

(B) Emergency room—two hundred fifty dollars (\$250) network and non-network. Deductible and coinsurance requirements apply to emergency room services in addition to the copayment. If a member is admitted to the hospital or the claims administrator considers the claim to be for a true emergency, the copayment is waived.

(C) Inpatient hospitalization—two hundred dollars (\$200) per admission for network and non-network. Deductible and coinsurance requirements apply to inpatient hospitalization services in addition to the copayment.

(11) Maximum plan payment—non-network medical claims that are not otherwise subject to a contractual discount arrangement are allowed at one hundred ten percent (110%) of Medicare reimbursement. Members may be held liable for the amount of the fee above the allowed amount.

(12) Any claim must be initially submitted within twelve (12) months following the date of service. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

(13) For a member who is an inpatient on the last calendar day of a plan year and remains an inpatient into the next plan year, the prior plan year's applicable copayment, deductible and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

(14) Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-2.055. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as a non-network benefit. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

(15) Medicare.

(A) When MCHCP becomes aware that the member is eligible for Medicare benefits claims will be processed reflecting Medicare coverage.

(B) If a member does not enroll in Medicare when s/he is eligible and Medicare should be the member's primary plan, the member will be responsible for paying the portion Medicare would have paid. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

(C) If a Medicare primary member chooses a provider who has opted out of Medicare, the member will be responsible for paying the portion Medicare would have paid if the service was performed by a Medicare provider. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Original rule filed Oct. 31, 2018.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

PROPOSED RESCISSION

22 CSR 10-2.051 PPO 300 Plan Benefit Provisions and Covered Charges. This rule established the policy of the board of trustees in regard to the PPO 300 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded because the PPO 300 Plan will not be offered after December 31, 2018.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the Code of State Regulations. Emergency rescission filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Rescinded: Filed Oct. 31, 2018.

PUBLIC COST: This proposed rescission will not cost state agencies

or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

PROPOSED RESCISSION

22 CSR 10-2.052 PPO 600 Plan Benefit Provisions and Covered Charges. This rule established the policy of the board of trustees in regard to the PPO 600 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded because the PPO 600 Plan will not be offered after December 31, 2018.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. For intervening history, please consult the Code of State Regulations. Emergency rescission filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Rescinded: Filed Oct. 31, 2018.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

PROPOSED AMENDMENT

22 CSR 10-2.053 Health Savings Account Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (1), (3), (6), (8), (10), (11), (12), (13), (17), (18), (19), and (20); and removing section (18).

PURPOSE: This amendment revises the HSA Plan deductible, out-of-pocket maximum and clarifies influenza vaccinations, diabetes self-management education/training, family deductible, access to payment information, deductible and out-of-pocket accumulations, maximum

plan payments, HSA Plan eligibility, and Health Savings Account contributions when both spouses are state employees.

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Health Savings Account (HSA) Plan, benefit provisions, and covered charges of the Missouri Consolidated Health Care Plan.

(1) Deductible—per calendar year for network: per individual, one thousand six hundred fifty dollars (\$1,650); family, three thousand three hundred dollars (\$3,300) and for non-network: per individual, *[four thousand dollars (\$4,000)]* **three thousand three hundred dollars (\$3,300)**; family, *[eight thousand dollars (\$8,000)]* **six thousand six hundred dollars (\$6,600)**.

(3) Out-of-pocket maximum.

(A) The family out-of-pocket maximum applies when two (2) or more family members are covered. The family out-of-pocket maximum must be met before the plan begins to pay one hundred percent (100%) of all covered charges for any covered family member. Out-of-pocket maximums are per calendar year, as follows:

1. Network out-of-pocket maximum for individual—*[three thousand three hundred dollars (\$3,300)]* **four thousand nine hundred fifty dollars (\$4,950)**;

2. Network out-of-pocket maximum for family—*[six thousand six hundred dollars (\$6,600)]* **nine thousand nine hundred dollars (\$9,900)**. **Any individual family member need only incur a maximum of seven thousand nine hundred dollars (\$7,900) before the plan begins paying one hundred percent (100%) of covered charges for that individual;**

3. Non-network out-of-pocket maximum for individual—*[five thousand dollars (\$5,000)]* **nine thousand nine hundred dollars (\$9,900)**; and

4. Non-network out-of-pocket maximum for family—*[ten thousand dollars (\$10,000)]* **nineteen thousand eight hundred dollars (\$19,800)**.

(6) Influenza *[immunizations]* **vaccinations** provided by a non-network provider will be reimbursed up to twenty-five dollars (\$25) once the member submits a receipt and a reimbursement form to the claims administrator.

(8) Four (4) diabetes **self-management** education/training visits with a certified diabetes educator when ordered by a provider and received through a network provider are covered at one hundred percent (100%) after deductible is met.

(10) Married, active employees who are MCHCP subscribers and have enrolled children may meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must provide the other spouse's Social Security number (SSN) and report the other spouse as eligible for coverage when newly hired and during the open enrollment process. In the medical plan vendor **and pharmacy benefit manager** system, the spouse with children enrolled will be considered the subscriber and the spouse that does not have children enrolled will be considered a dependent. If both spouses have children enrolled the spouse with the higher Social Security number (SSN) will be considered the subscriber. Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

(11) Each subscriber will have access to payment information of the family unit **only when authorization is granted by the adult covered dependent(s)**.

(12) Expenses toward the deductible and out-of-pocket maximum

will be transferred if the member changes **non-Medicare** medical plans or continues enrollment under another subscriber's **non-Medicare medical** plan within the same plan year.

(13) *[Usual, customary, and reasonable fee allowed]* **Maximum plan payment**—Non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed at *[the eightieth percentile of usual, customary, and reasonable fees as determined by the vendor]* **one hundred ten percent (110%) of Medicare reimbursement**. Members may be held liable for the amount of the fee above the allowed amount.

(17) **An active employee** subscriber does not qualify for the HSA Plan if s/he is claimed as a dependent on another person's tax return or, except for the plans listed in section *[(20)]* **(19)** of this rule, is covered under or enrolled in any other health plan that is not a high deductible health plan, including, but not limited to, the following types of insurance plans or programs:

[(18) If a retiree subscriber and/or his/her dependent(s) becomes eligible for Medicare in the upcoming plan year then s/he may not enroll in the HSA Plan during open enrollment.]

*[(19)]***(18)** If an **active employee** subscriber and/or his/her dependent(s) is enrolled in the HSA Plan and becomes ineligible for the HSA Plan during the plan year, the subscriber and/or his/her dependent(s) will be enrolled in the PPO *[600]* **1250** Plan. The subscriber may enroll in a different non-HSA Plan within thirty-one (31) days of notice from MCHCP.

*[(20)]***(19)** A subscriber may qualify for this plan even if s/he is covered by any of the following:

- (A) Drug discount card;
- (B) Accident insurance;
- (C) Disability insurance;
- (D) Dental insurance;
- (E) Vision insurance; or
- (F) Long-term care insurance.

*[(21)]***(20)** Health Savings Account (HSA) Contributions.

(A) To receive contributions from MCHCP, the subscriber must be an active employee and HSA eligible as defined in the Internal Revenue Service Publication 969 on the date the contribution is made and open an HSA with the bank designated by MCHCP.

1. Subscribers who enroll in the HSA Plan during open enrollment who have a balance in a health care FSA on January 1 of the new plan year cannot receive an HSA contribution from MCHCP until after the health care FSA grace period ends March 15.

(B) A new employee or subscriber electing coverage due to a life event or loss of employer-sponsored coverage with an effective date after the MCHCP contribution will receive an applicable prorated contribution. Unless a subscriber is eligible for a special enrollment period, a subscriber will not be able to voluntarily change his/her plan selection.

(C) A subscriber who moves from subscriber-only coverage to another coverage level with an effective date after the MCHCP contribution will receive an applicable prorated contribution based on the increased level of coverage.

(D) If a subscriber moves from another coverage level to subscriber-only coverage, cancels all coverage, or MCHCP terminates coverage and has received an HSA contribution, MCHCP will not request a re-payment of the contribution.

(E) If both *[a husband and wife]* **spouses** are state employees covered by MCHCP and they both enroll in an HSA Plan, they must each have a separate HSA. The maximum contribution MCHCP will make for the family is six hundred dollars (\$600) regardless of the number of HSAs or the number of children covered under the HSA

Plan for either parent. MCHCP will consider married state employees as one (1) family and will not make two (2) family contributions to both spouses or one (1) family contribution and one (1) individual contribution. MCHCP will make a maximum three hundred dollar (\$300) contribution to each spouse to total maximum six hundred dollars (\$600).

(F) The MCHCP contributions will be deposited into the subscriber's HSA as follows:

1. The January deposit will be made on the third Monday of the month, or the first working day after the third Monday if the third Monday is a holiday;

2. The April deposit will be made on the first Monday in April; and

3. Other deposits will be made on the first Monday of the month in which coverage is effective, or the first working day after the first Monday of the month coverage is effective if the first Monday is a state holiday.

Deposit	Subscriber Only	All other coverage levels
January	\$300.00	\$600.00
April (delayed contribution due to health care FSA grace period)	\$300.00	\$600.00
All others	A proration of \$300	A proration of \$600

AUTHORITY: sections 103.059 and 103.080.3., RSMo 2016. Emergency rule filed Dec. 22, 2008, effective Jan. 1, 2009, expired June 29, 2009. Original rule filed Dec. 22, 2008, effective June 30, 2009. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Amended: Filed Oct. 31, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

PROPOSED AMENDMENT

22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (1) and (3).

PURPOSE: This amendment revises the names of the medical plans and clarifies the following benefits: dental care, diabetes education, dialysis, genetic counseling, infusions, injections, nutrition counseling, and preventive services; alphabetizes the list of medical benefits; and renumbers as necessary.

(1) Benefit Provisions Applicable to the PPO [300] 750 Plan, PPO [600] 1250 Plan, and Health Savings Account (HSA) Plan. Subject

to the plan provisions, limitations, and enrollment of the employee, the benefits are payable for covered charges incurred by a member while covered under the plans, provided the deductible requirement, if any, is met.

(3) Covered Charges Applicable to the PPO [300] 750 Plan, PPO [600] 1250, and HSA Plan.

(E) Plan benefits for the PPO [300] 750 Plan, PPO [600] 1250, and HSA Plan are as follows:

1. Allergy Testing and Immunotherapy. Allergy testing and allergy immunotherapy are considered medically necessary for members with clinically significant allergic symptoms. The following tests and treatments are covered:

A. Epicutaneous (scratch, prick, or puncture) when Immunoglobulin E- (IgE-) mediated reactions occur to any of the following:

- (I) Foods;
- (II) Hymenoptera venom (stinging insects);
- (III) Inhalants; or
- (IV) Specific drugs (penicillins and macromolecular agents);

B. Intradermal (Intracutaneous) when IgE-mediated reactions occur to any of the following:

- (I) Foods;
- (II) Hymenoptera venom (stinging insects);
- (III) Inhalants; or
- (IV) Specific drugs (penicillins and macromolecular agents);

C. Skin or Serial Endpoint Titration (SET), also known as intradermal dilutional testing (IDT), for determining the starting dose for immunotherapy for members highly allergic to any of the following:

- (I) Hymenoptera venom (stinging insects); or
- (II) Inhalants;

D. Skin Patch Testing: for diagnosing contact allergic dermatitis;

E. Photo Patch Testing: for diagnosing photo-allergy (such as photo-allergic contact dermatitis);

F. Photo Tests: for evaluating photo-sensitivity disorders;

G. Bronchial Challenge Test: for testing with methacholine, histamine, or antigens in defining asthma or airway hyperactivity when either of the following conditions is met:

- (I) Bronchial challenge test is being used to identify new allergens for which skin or blood testing has not been validated; or
- (II) Skin testing is unreliable;

H. Exercise Challenge Testing for exercise-induced bronchospasm;

I. Ingestion (Oral) Challenge Test for any of the following:

- (I) Food or other substances; or
- (II) Drugs when all of the following are met:
 - (a) History of allergy to a particular drug;
 - (b) There is no effective alternative drug; and
 - (c) Treatment with that drug class is essential;

J. In Vitro IgE Antibody Tests (RAST, MAST, FAST, ELISA, ImmunoCAP) are covered for any of the following:

- (I) Allergic broncho-pulmonary aspergillosis (ABPA) and certain parasitic diseases;
- (II) Food allergy;
- (III) Hymenoptera venom allergy (stinging insects);
- (IV) Inhalant allergy; or
- (V) Specific drugs;

K. Total Serum IgE for diagnostic evaluation in members with known or suspected ABPA and/or hyper IgE syndrome;

L. Lymphocyte transformation tests such as lymphocyte mitogen response test, PHE stimulation test, or lymphocyte antigen response assay are covered for evaluation of persons with any of the following suspected conditions:

- (I) Sensitivity to beryllium;
- (II) Congenital or acquired immunodeficiency diseases affecting cell-mediated immunity, such as severe combined immunodeficiency, common variable immunodeficiency, X-linked immunodeficiency with hyper IgM, Nijmegen breakage syndrome, reticular

dysgenesis, DiGeorge syndrome, Nezelof syndrome, Wiscott-Aldrich syndrome, ataxia telangiectasia, and chronic mucocutaneous candidiasis;

(III) Thymoma; and

(IV) To predict allograft compatibility in the transplant setting;

M. Allergy retesting: routine allergy retesting is not considered medically necessary;

N. Allergy immunotherapy is covered for the treatment of any of the following IgE-mediated allergies:

(I) Allergic (extrinsic) asthma;

(II) Dust mite atopic dermatitis;

(III) Hymenoptera (bees, hornets, wasps, fire ants) sensitive individuals;

(IV) Mold-induced allergic rhinitis;

(V) Perennial rhinitis;

(VI) Seasonal allergic rhinitis or conjunctivitis when one (1) of the following conditions are met:

(a) Member has symptoms of allergic rhinitis or asthma after natural exposure to the allergen;

(b) Member has a life-threatening allergy to insect stings; or

(c) Member has skin test or serologic evidence of IgE mediated antibody to a potent extract of the allergen; and

(VII) Avoidance or pharmacologic therapy cannot control allergic symptoms or member has unacceptable side effects with pharmacologic therapy;

O. Other treatments: the following other treatments are covered:

(I) Rapid, rush, cluster, or acute desensitization for members with any of the following conditions:

(a) IgE antibodies to a particular drug that cannot be treated effectively with alternative medications;

(b) Insect sting (e.g., wasps, hornets, bees, fire ants) hypersensitivity (hymenoptera); or

(c) Members with moderate to severe allergic rhinitis who need treatment during or immediately before the season of the affecting allergy;

(II) Rapid desensitization is considered experimental and investigational for other indications;

P. Epinephrine kits, to prevent anaphylactic shock for members who have had life-threatening reactions to insect stings, foods, drugs, or other allergens; have severe asthma or if needed during immunotherapy;

2. Ambulance service. The following ambulance transport services are covered:

A. By ground to the nearest appropriate facility when other means of transportation would be contraindicated;

B. By air to the nearest appropriate facility when the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate or contraindicated;

3. Applied Behavior Analysis (ABA) for Autism;

4. Bariatric surgery. Bariatric surgery is covered when all of the following requirements have been met:

A. The surgery is performed at a facility accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) for the billed procedure;

B. The following open or laparoscopic bariatric surgery procedures are covered:

(I) Roux-en-Y gastric bypass;

(II) Sleeve gastrectomy;

(III) Biliopancreatic diversion with duodenal switch for individuals with a body mass index (BMI) greater than fifty (50);

(IV) Adjustable silicone gastric banding and adjustments of a silicone gastric banding to control the rate of weight loss and/or treat symptoms secondary to gastric restriction following an adjustable silicone gastric banding procedure;

(V) Surgical reversal of bariatric surgery when complica-

tions of the original surgery (e.g., stricture, pouch dilatation, erosion, or band slippage) cause abdominal pain, inability to eat or drink, or cause vomiting of prescribed meals;

(VI) Revision of a previous bariatric surgical procedure or conversion to another procedure due to inadequate weight loss when one (1) of the following specific criteria has been met:

(a) There is evidence of full compliance with the previously prescribed post-operative dietary and exercise program; or

(b) There is documented clinical testing demonstrating technical failure of the original bariatric surgical procedure which caused the individual to fail achieving adequate weight loss of at least fifty percent (50%) of excess body weight or failure to achieve body weight to within thirty percent (30%) of ideal body weight at least two (2) years following the original surgery;

C. All of the following criteria have been met:

(I) The member is eighteen (18) years or older or has reached full skeletal growth, and has evidence of one (1) of the following:

(a) BMI greater than forty (40); or

(b) BMI between thirty-five (35) and thirty-nine and nine tenths (39.9) and one (1) or more of the following:

I. Type II diabetes;

II. Cardiovascular disease such as stroke, myocardial infarction, stable or unstable angina pectoris, hypertension, or coronary artery bypass; or

III. Life-threatening cardiopulmonary problems such as severe sleep apnea, Pickwickian syndrome, or obesity-related cardiomyopathy; and

(II) Demonstration that dietary attempts at weight control have been ineffective through completion of a structured diet program. Commercial weight loss programs are acceptable if completed under the direction of a provider or registered dietitian and documentation of participation is available for review. One (1) structured diet program for six (6) consecutive months or two (2) structured diet programs for three (3) consecutive months each within a two- (2-) year period prior to the request for the surgical treatment of morbid obesity are sufficient. Provider-supervised programs consisting exclusively of pharmacological management are not sufficient; and

(III) A thorough multidisciplinary evaluation within the previous twelve (12) months, which include all of the following:

(a) An evaluation by a bariatric surgeon recommending surgical treatment, including a description of the proposed procedure and all of the associated current procedural terminology codes;

(b) A separate medical evaluation from a provider other than the surgeon recommending surgery that includes a medical clearance for bariatric surgery;

(c) Completion of a psychological examination from a mental health provider evaluating the member's readiness and fitness for surgery and the necessary post-operative lifestyle changes. After the evaluation, the mental health provider must provide clearance for bariatric surgery; and

(d) A nutritional evaluation by a provider or registered dietitian;

5. Blood storage. Storage of whole blood, blood plasma, and blood products is covered in conjunction with medical treatment that requires immediate blood transfusion support;

/5./6. Bone Growth Stimulators. Implantable bone growth stimulators are covered as an outpatient surgery benefit. The following nonimplantable bone growth stimulators are covered as a durable medical equipment benefit:

A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)) to accelerate healing of fresh fractures, fusions, or delayed unions at either of the following high-risk sites:

(I) Fresh fractures, fusions, or delayed unions of the shaft (diaphysis) of the tibia that are open or segmental; or

(II) Fresh fractures, fusions, or delayed unions of the scaphoid (carpal navicular);

B. Ultrasonic osteogenesis stimulator for non-unions, failed

arthrodesis, and congenital pseudarthrosis (pseudoarthrosis) of the appendicular skeleton if there has been no progression of healing for three (3) or more months despite appropriate fracture care; or

C. Direct current electrical bone-growth stimulator is covered for the following indications:

(I) Delayed unions of fractures or failed arthrodesis at high-risk sites (i.e., open or segmental tibial fractures, carpal navicular fractures);

(II) Non-unions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three (3) or more months despite appropriate fracture care; or

(III) Members who are at high risk for spinal fusion failure when any of the following criteria is met:

(a) A multiple-level fusion entailing three (3) or more vertebrae (e.g., L3 to L5, L4 to S1, etc.);

(b) Grade II or worse spondylolisthesis; or

(c) One (1) or more failed fusions;

[6./7. Contraception and Sterilization. All Food and Drug Administration- (FDA-) approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity;

[7. Blood storage. *Storage of whole blood, blood plasma, and blood products is covered in conjunction with medical treatment that requires immediate blood transfusion support;]*

8. Cardiac rehabilitation. An electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) is covered for specific criteria when it is individually prescribed by a provider and a formal exercise stress test is completed following the event and prior to the initiation of the program. Cardiac rehabilitation is covered for members who meet one (1) of the following criteria:

A. Acute myocardial infarction (MI) (heart attack in the last twelve (12) months);

B. Coronary artery bypass grafting (CABG);

C. Stable angina pectoris;

D. Percutaneous coronary vessel remodeling;

E. Valve replacement or repair;

F. Heart transplant;

G. Coronary artery disease (CAD) associated with chronic stable angina that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities; or

H. Heart failure that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities;

9. Chelation therapy. The administration of FDA-approved chelating agents is covered for any of the following conditions:

A. Genetic or hereditary hemochromatosis;

B. Lead overload in cases of acute or long-term lead exposure;

C. Secondary hemochromatosis due to chronic iron overload due to transfusion-dependent anemias (e.g., Thalassemias, Cooley's anemia, sickle cell anemia, sideroblastic anemia);

D. Copper overload in patients with Wilson's disease;

E. Arsenic, mercury, iron, copper, or gold poisoning when long-term exposure to and toxicity has been confirmed through lab results or clinical findings consistent with metal toxicity;

F. Aluminum overload in chronic hemodialysis patients;

G. Emergency treatment of hypercalcemia;

H. Prophylaxis against doxorubicin-induced cardiomyopathy;

I. Internal plutonium, americium, or curium contamination;

or

J. Cystinuria;

10. Chiropractic services. Chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) are covered when all of the following conditions are met:

A. A neuromusculoskeletal condition is diagnosed that may

be relieved by standard chiropractic treatment in order to restore optimal function;

B. Chiropractic care is being performed by a licensed doctor of chiropractic who is practicing within the scope of his/her license as defined by state law;

C. The individual is involved in a treatment program that clearly documents all of the following:

(I) A prescribed treatment program that is expected to result in significant therapeutic improvement over a clearly defined period of time;

(II) The symptoms being treated;

(III) Diagnostic procedures and results;

(IV) Frequency, duration, and results of planned treatment modalities;

(V) Anticipated length of treatment plan with identification of quantifiable, attainable short-term and long-term goals; and

(VI) Demonstrated progress toward significant functional gains and/or improved activity tolerances;

D. Following previous successful treatment with chiropractic care, acute exacerbation or re-injury are covered when all of the following criteria are met:

(I) The member reached maximal therapeutic benefit with prior chiropractic treatment;

(II) The member was compliant with a self-directed home-care program;

(III) Significant therapeutic improvement is expected with continued treatment; and

(IV) The anticipated length of treatment is expected to be short-term (e.g., no more than six (6) visits within a three- (3-) week period);

11. Clinical trials. Routine member care costs incurred as the result of a Phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition are covered when—

A. The study or investigation is conducted under an investigational new drug application reviewed by the FDA; or

B. Is a drug trial that is exempt from having such an investigational new drug application. Life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted; and

C. Routine member care costs include all items and services consistent with the coverage provided in plan benefits that would otherwise be covered for a member not enrolled in a clinical trial. Routine patient care costs do not include the investigational item, device, or service itself; items and services that are provided solely to satisfy data collection and analysis needs and are not used in the direct clinical management of the member; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

D. The member must be eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

E. The clinical trial must be approved or funded by one (1) of the following:

(I) National Institutes of Health (NIH);

(II) Centers for Disease Control and Prevention (CDC);

(III) Agency for Health Care Research and Quality;

(IV) Centers for Medicare & Medicaid Services (CMS);

(V) A cooperative group or center of any of the previously named agencies or the Department of Defense or the Department of Veterans Affairs;

(VI) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

(VII) A study or investigation that is conducted by the Department of Veterans Affairs, the Department of Defense, or the Department of Energy and has been reviewed and approved to be comparable to the system of peer review of studies and investigations used by the NIH and assures unbiased review of the highest scientific

standards by qualified individuals who have no interest in the outcome of the review;

12. Cochlear implant device. Uniaural (monaural) or binaural (bilateral) cochlear implantation and necessary replacement batteries are covered for a member with bilateral, pre- or post-linguistic, sensorineural, moderate-to-profound hearing impairment when there is reasonable expectation that a significant benefit will be achieved from the device and when the following age-specific criteria are met:

A. Auditory brainstem implant. Auditory brainstem implant (ABI) covered for the diagnosis of neurofibromatosis type II, von Recklinghausen's disease, or when a member is undergoing bilateral removal of tumors of the auditory nerves, and it is anticipated that the member will become completely deaf as a result of the surgery, or the member had bilateral auditory nerve tumors removed and is now bilaterally deaf;

(I) For an adult (age eighteen (18) years or older) with BOTH of the following:

(a) Bilateral, severe to profound sensorineural hearing loss determined by a pure-tone average of seventy (70) decibels (dB) hearing loss or greater at five hundred (500) hertz (Hz), one thousand (1000) Hz, and two thousand (2000) Hz; and

(b) Member has limited benefit from appropriately fitted binaural hearing aids. Limited benefit from amplification is defined by test scores of forty percent (40%) correct or less in best-aided listening condition on open-set sentence cognition (e.g., Central Institute for the Deaf (CID) sentences, Hearing in Noise Test (HINT) sentences, and Consonant-Nucleus-Consonant (CNC) test);

(II) For a child age twelve (12) months to seventeen (17) years, eleven (11) months with both of the following:

(a) Profound, bilateral sensorineural hearing loss with thresholds of ninety (90) dB or greater at one thousand (1000) Hz; and

(b) Limited or no benefit from a three- (3-) month trial of appropriately fitted binaural hearing aids;

(III) For children four (4) years of age or younger, with one (1) of the following:

(a) Failure to reach developmentally appropriate auditory milestones measured using the Infant-Toddler Meaningful Auditory Integration Scale, the Meaningful Auditory Integration Scale, or the Early Speech Perception test; or

(b) Less than twenty percent (20%) correct on open-set word recognition test Multisyllabic Lexical Neighborhood Test (MLNT) in conjunction with appropriate amplification and participation in intensive aural habilitation over a three- (3-) to six- (6-) month period;

(IV) For children older than four (4) years of age with one (1) of the following:

(a) Less than twelve percent (12%) correct on the Phonetically Balanced-Kindergarten Test; or

(b) Less than thirty percent (30%) correct on the HINT for children, the open-set Multisyllabic Lexical Neighborhood Test (MLNT) or Lexical Neighborhood Test (LNT), depending on the child's cognitive ability and linguistic skills; and

(V) A three- (3-) to six- (6-) month hearing aid trial has been undertaken by a child without previous experience with hearing aids;

B. Radiologic evidence of cochlear ossification;

C. The following additional medical necessity criteria must also be met for uniaural (monaural) or binaural (bilateral) cochlear implantation in adults and children:

(I) Member must be enrolled in an educational program that supports listening and speaking with aided hearing;

(II) Member must have had an assessment by an audiologist and from an otolaryngologist experienced in this procedure indicating the likelihood of success with this device;

(III) Member must have no medical contraindications to cochlear implantation (e.g., cochlear aplasia, active middle ear infection); and

(IV) Member must have arrangements for appropriate fol-

low-up care, including the speech therapy required to take full advantage of this device;

D. A second cochlear implant is covered in the contralateral (opposite) ear as medically necessary in an individual with an existing unilateral cochlear implant when the hearing aid in the contralateral ear produces limited or no benefit;

E. The replacement of an existing cochlear implant is covered when either of the following criteria is met:

(I) Currently used component is no longer functional and cannot be repaired; or

(II) Currently used component renders the implant recipient unable to adequately and/or safely perform his/her age-appropriate activities of daily living; and

F. Post-cochlear or ABI rehabilitation program (aural rehabilitation) is covered to achieve benefit from a covered device;

13. Dental care.

A. Dental care is covered for the following:

(I) Treatment to reduce trauma and restorative services limited to dental implants only when the result of accidental injury to sound natural teeth and tissue that are viable, functional, and free of disease. **Treatment must be initiated within sixty (60) days of accident;** and

(II) Restorative services limited to dental implants when needed as a result of cancerous or non-cancerous tumors and cysts, cancer, and post-surgical sequelae.

B. The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization when provided in a network or non-network hospital or surgical center;

14. Diabetes self-management training//E/education when prescribed by a provider and taught by a Certified Diabetes Educator through a medical network provider;

15. Dialysis is covered when received through a network provider;

15./16. Durable medical equipment (DME) is covered when ordered by a provider to treat an injury or illness. DME includes, but is not limited to, the following:

A. Insulin pumps;

B. Oxygen;

C. Augmentative communication devices;

D. Manual and powered mobility devices;

E. Disposable supplies that do not withstand prolonged use and are periodically replaced, including, but not limited to, the following:

(I) Colostomy and ureterostomy bags;

(II) Prescription compression stockings limited to two (2) pairs or four (4) individual stockings per plan year;

F. Blood pressure cuffs/monitors with a diagnosis of diabetes;

G. Repair and replacement of DME is covered when any of the following criteria are met:

(I) Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

(II) Routine wear and tear of the equipment renders it non-functional and the member still requires the equipment; or

(III) The provider has documented that the condition of the member changes or if growth-related;

16./17. Emergency room services. Coverage is for emergency medical conditions. If a member is admitted to the hospital, s/he may be required to transfer to network facility for maximum benefit. Hospital and ancillary charges are paid as a network benefit;

17./18. Eye glasses and contact lenses. Coverage limited to charges incurred in connection with the fitting of eye glasses or contact lenses for initial placement within one (1) year following cataract surgery;

18./19. Foot care (trimming of nails, corns, or calluses). Foot care services are covered when administered by a provider and—

A. When associated with systemic conditions that are significant enough to result in severe circulatory insufficiency or areas of desensitization in the lower extremities including, but not limited to, any of the following:

- (I) Diabetes mellitus;
- (II) Peripheral vascular disease; or
- (III) Peripheral neuropathy.

(IV) Evaluation/debridement of mycotic nails, in the absence of a systemic condition, when both of the following conditions are met:

(a) Pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate; and

(b) If the member is ambulatory, pain markedly limits ambulation;

[19.]20. Genetic counseling. Pre-test and post-test genetic counseling with a provider or a licensed or certified genetic counselor are covered when a member is recommended for covered heritable genetic testing.

A. Genetic counseling in connection with pregnancy management is covered only for evaluation of any of the following:

(I) Couples who are closely related genetically (e.g., consanguinity, incest);

(II) Familial cancer disorders;

(III) Individuals recognized to be at increased risk for genetic disorders;

(IV) Infertility cases where either parent is known to have a chromosomal abnormality;

(V) Primary amenorrhea, azoospermia, abnormal sexual development, or failure in developing secondary sexual characteristics;

(VI) Mother is a known, or presumed carrier of an X linked recessive disorder;

(VII) One (1) or both parents are known carriers of an autosomal recessive disorder;

(VIII) Parents of a child born with a genetic disorder, birth defect, inborn error of metabolism, or chromosome abnormality;

(IX) Parents of a child with intellectual developmental disorders, autism, developmental delays, or learning disabilities;

(X) Pregnant women who, based on prenatal ultrasound tests or an abnormal multiple marker screening test, maternal serum alpha-fetoprotein (AFP) test, test for sickle cell anemia, or tests for other genetic abnormalities have been told their pregnancy may be at increased risk for complications or birth defects;

(XI) Pregnant women age thirty-five (35) years or older at delivery;

(XII) Pregnant women, or women planning pregnancy, exposed to potentially teratogenic, mutagenic, or carcinogenic agents such as chemicals, drugs, infections, or radiation;

(XIII) Previous unexplained stillbirth or repeated (three (3) or more; two (2) or more among infertile couples) first-trimester miscarriages, where there is suspicion of parental or fetal chromosome abnormalities; or

(XIV) When contemplating pregnancy, either parent affected with an autosomal dominant disorder;

[20.]21. Genetic testing.

A. Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following criteria are met:

(I) The member displays clinical features or is at direct risk of inheriting the mutation in question (pre-symptomatic);

(II) The result of the test will directly impact the treatment being delivered to the member;

(III) The testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and

(IV) After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain/./.

B. Genetic testing for the breast cancer susceptibility gene (BRCA) when family history is present;

[21.]22. Hair analysis. Chemical hair analysis is covered for the diagnosis of suspected chronic arsenic poisoning. Other purposes are considered experimental and investigational;

[22.]23. Hair prostheses. Prostheses and expenses for scalp hair prostheses worn for hair loss are covered for alopecia areata or alopecia totalis for children eighteen (18) years of age or younger. The annual maximum is two hundred dollars (\$200), and the lifetime maximum is three thousand two hundred dollars (\$3,200);

[23.]24. Hearing aids (per ear). Hearing aids covered for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss.

A. Prior to receiving a hearing aid members must receive—

(I) A medical exam by a physician or other qualified provider to identify any medically treatable conditions that may affect hearing; and

(II) A comprehensive hearing test to assess the need for hearing aids conducted by a certified audiologist, hearing instrument specialist, or other provider licensed or certified to administer this test.

B. Covered once every two (2) years. If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

(I) Conventional: one thousand dollars (\$1,000).

(II) Programmable: two thousand dollars (\$2,000).

(III) Digital: two thousand five hundred dollars (\$2,500).

(IV) Bone Anchoring Hearing Aid (BAHA): three thousand five hundred dollars (\$3,500);

[24.]25. Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by provider;

[25.]26. Home health care. Skilled home health nursing care is covered for members who are homebound because of injury or illness (i.e., the member leaves home only with considerable and taxing effort, and absences from home are infrequent or of short duration, or to receive medical care). Services must be performed by a registered nurse or licensed practical nurse, licensed therapist, or a registered dietitian. Covered services include:

A. Home visits instead of visits to the provider's office that do not exceed the usual and customary charge to perform the same service in a provider's office;

B. Intermittent nurse services. Benefits are paid for only one (1) nurse at any one (1) time, not to exceed four (4) hours per twenty-four- (24-) hour period;

C. Nutrition counseling provided by or under the supervision of a registered dietitian;

D. Physical, occupational, respiratory, and speech therapy provided by or under the supervision of a licensed therapist;

E. Medical supplies, drugs, or medication prescribed by provider, and laboratory services to the extent that the plan would have covered them under this plan if the covered person had been in a hospital;

F. A home health care visit is defined as—

(I) A visit by a nurse providing intermittent nurse services (each visit includes up to a four- (4-) hour consecutive visit in a twenty-four- (24-) hour period if clinical eligibility for coverage is met) or a single visit by a therapist or a registered dietitian; and

G. Benefits cannot be provided for any of the following:

(I) Homemaker or housekeeping services;

(II) Supportive environment materials such as handrails, ramps, air conditioners, and telephones;

(III) Services performed by family members or volunteer workers;

(IV) "Meals on Wheels" or similar food service;

(V) Separate charges for records, reports, or transportation;

(VI) Expenses for the normal necessities of living such as food, clothing, and household supplies; and

(VII) Legal and financial counseling services, unless otherwise covered under this plan;

[26.]27. Hospice care and palliative services (inpatient or outpatient). Includes bereavement and respite care. Hospice care services, including pre-hospice evaluation or consultation, are covered when the individual is terminally ill and expected to live six (6) months or less, potentially curative treatment for the terminal illness is not part of the prescribed plan of care, the individual or appointed designee has formally consented to hospice care (i.e., care directed mostly toward palliative care and symptom management), and the hospice services are provided by a certified/accredited hospice agency with care available twenty-four (24) hours per day, seven (7) days per week.

A. When the above criteria are met, the following hospice care services are covered:

(I) Assessment of the medical and social needs of the terminally ill person, and a description of the care to meet those needs;

(II) Inpatient care in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy, and part-time home health care services;

(III) Outpatient care for other services as related to the terminal illness, which include services of a physician, physical or occupational therapy, and nutrition counseling provided by or under the supervision of a registered dietitian; and

(IV) Bereavement counseling benefits which are received by a member's close relative when directly connected to the member's death and bundled with other hospice charges. The services must be furnished within twelve (12) months of death;

[27.]28. Hospital (includes inpatient, outpatient, and surgical centers).

A. The following benefits are covered:

(I) Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a covered expense only when clinical eligibility for coverage is met. If the hospital has no semi-private rooms, the plan will allow the private room rate subject to usual, customary, and reasonable charges or the network rate, whichever is applicable;

(II) Intensive care unit room and board;

(III) Surgery, therapies, and ancillary services including, but not limited to:

(a) Cornea transplant;

(b) Coverage for breast reconstruction surgery or prostheses following mastectomy and lumpectomy is available to both females and males. A diagnosis of breast cancer is not required for breast reconstruction services to be covered, and the timing of reconstructive services is not a factor in coverage;

(c) Sterilization for the purpose of birth control is covered;

(d) Cosmetic/reconstructive surgery is covered to repair a functional disorder caused by disease or injury;

(e) Cosmetic/reconstructive surgery is covered to repair a congenital defect or abnormality for a member younger than nineteen (19) years; and

(f) Blood, blood plasma, and plasma expanders are covered, when not available without charge;

(IV) Inpatient mental health services are covered when authorized by a physician for treatment of a mental health disorder. Inpatient mental health services are covered, subject to all of the following:

(a) Member must be ill in more than one (1) area of daily living to such an extent that s/he is rendered dysfunctional and requires the intensity of an inpatient setting for treatment. Without such inpatient treatment, the member's condition would deteriorate;

(b) The member's mental health disorder must be treatable in an inpatient facility;

(c) The member's mental health disorder must meet diagnostic criteria as described in the most recent edition of the *American Psychiatric Association Diagnostic and Statistical Manual (DSM)*. If outside of the United States, the member's mental health

disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region;

(d) The attending provider must be a psychiatrist. If the admitting provider is not a psychiatrist, a psychiatrist must be attending to the member within twenty-four (24) hours of admittance. Such psychiatrist must be United States board-eligible or board-certified. If outside of the United States, inpatient services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending provider must meet the requirements, if any, set out by the foreign government or regionally-recognized licensing body for treatment of mental health disorders;

(e) Day treatment (partial hospitalization) for mental health services means a day treatment program that offers intensive, multidisciplinary services provided on less than a full-time basis. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and pre-occupational modalities. Such programs must be a less-restrictive alternative to inpatient treatment; and

(f) Mental health services received in a residential treatment facility that is licensed by the state in which it operates and provides treatment for mental health disorders is covered. This does not include services provided at a group home. If outside of the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and

(V) Outpatient mental health services are covered if the member is at a therapeutic medical or mental health facility and treatment includes measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident. Treatment must be provided by one (1) of the following:

(a) A United States board-eligible or board-certified psychiatrist licensed in the state where the treatment is provided;

(b) A therapist with a doctorate or master's degree that denotes a specialty in psychiatry (Psy.D.);

(c) A state-licensed psychologist;

(d) A state-licensed or certified social worker practicing within the scope of his or her license or certification; or

(e) Licensed professional counselor;

29. Infusions are covered when received through a network provider. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered are not a medical plan benefit but are covered as part of the pharmacy benefit;

[28.]30. Injections [and infusions. *Injections and infusions are covered*]. See preventive services for coverage of [immunizations] vaccinations. See contraception and sterilization for coverage of birth control injections. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered[, including injectables,] are not a medical plan benefit but are covered as part of the pharmacy benefit.

A. B12 injections are covered for the following conditions:

(I) Pernicious anemia;

(II) Crohn's disease;

(III) Ulcerative colitis;

(IV) Inflammatory bowel disease;

(V) Intestinal malabsorption;

(VI) Fish tapeworm anemia;

(VII) Vitamin B12 deficiency;

(VIII) Other vitamin B12 deficiency anemia;

(IX) Macrocytic anemia;

(X) Other specified megaloblastic anemias;

(XI) Megaloblastic anemia;

(XII) Malnutrition of alcoholism;

(XIII) Thrombocytopenia, unspecified;

(XIV) Dementia in conditions classified elsewhere;

(XV) Polyneuropathy in diseases classified elsewhere;

(XVI) Alcoholic polyneuropathy;

- (XVII) Regional enteritis of small intestine;
- (XVIII) Postgastric surgery syndromes;
- (XIX) Other prophylactic chemo-therapy;
- (XX) Intestinal bypass or anastomosis status;
- (XXI) Acquired absence of stomach;
- (XXII) Pancreatic insufficiency; and
- (XXIII) Ideopathic progressive polyneuropathy;

/29./31. Lab, X-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition. Professional charges for automated lab services performed by an out-of-network provider are not covered;

/30./32. Maternity coverage. Prenatal and postnatal care is covered. Routine prenatal office visits and screenings recommended by the Health Resources and Services Administration are covered at one hundred percent (100%). Other care is subject to the deductible and coinsurance. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after vaginal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post discharge care that shall consist of a two- (2-) visit minimum, at least one (1) in the home;

/31./33. Nutritional counseling. Individualized nutritional evaluation and counseling for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program is covered when ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian);

/32./34. Nutrition therapy.

A. Nutrition therapy is covered only when the following criteria are met:

- (I) Nutrition therapy is the sole source of nutrients or a significant percentage of the daily caloric intake;
- (II) Nutrition therapy is used in the treatment of, or in association with, a demonstrable disease, condition, or disorder;
- (III) Nutrition therapy is necessary to sustain life or health;
- (IV) Nutrition therapy is prescribed by a provider; and
- (V) Nutrition therapy is managed, monitored, and evaluated on an on-going basis, by a provider.

B. Only the following types of nutrition therapy are covered:

(I) Enteral Nutrition (EN). EN is the provision of nutritional requirements via the gastrointestinal tract. EN can be taken orally or through a tube into the stomach or small intestine;

(II) Parenteral Nutrition Therapy (PN) and Total Parenteral Nutrition (TPN). PN is liquid nutrition administered through a vein to provide part of daily nutritional requirements. TPN is a type of PN that provides all daily nutrient needs. PN or TPN are covered when the member's nutritional status cannot be adequately maintained on oral or enteral feedings;

(III) Intradialytic Parenteral Nutrition (IDPN). IDPN is a type of PN that is administered to members on chronic hemodialysis during dialysis sessions to provide most nutrient needs. IDPN is covered when the member is on chronic hemodialysis and nutritional status cannot be adequately maintained on oral or enteral feedings;

/33./35. Office visit. Member encounter with a provider for health care, mental health, or substance use disorder in an office, clinic, or ambulatory care facility is covered based on the service, procedure, or related treatment plan;

/34./36. Oral surgery is covered for injury, tumors, or cysts. Oral surgery includes, but is not limited to, reduction of fractures and dislocation of the jaws; external incision and drainage of cellulites; incision of accessory sinuses, salivary glands, or ducts; excision of exostosis of jaws and hard palate; and frenectomy. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. Extractions of bony or partial bony impactions are excluded;

/35./37. Orthognathic or Jaw Surgery. Orthognathic or jaw surgery is covered when one (1) of the following conditions is documented and diagnosed:

- A. Acute traumatic injury, and post-surgical sequela;
- B. Cancerous or non-cancerous tumors and cysts, cancer, and post-surgical sequela;

C. Cleft lip/palate (for cleft lip/palate related jaw surgery); or
D. Physical or physiological abnormality when one (1) of the following criteria is met:

(I) Anteroposterior Discrepancies—

(a) Maxillary/Mandibular incisor relationship: over jet of 5mm or more, or a 0 to a negative value (norm 2mm);

(b) Maxillary/Mandibular anteroposterior molar relationship discrepancy of 4mm or more (norm 0 to 1mm); or

(c) These values represent two (2) or more standard deviation from published norms;

(II) Vertical Discrepancies—

(a) Presence of a vertical facial skeletal deformity which is two (2) or more standard deviations from published norms for accepted skeletal landmarks;

(b) Open bite with no vertical overlap of anterior teeth or unilateral or bilateral posterior open bite greater than 2mm;

(c) Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch; or

(d) Supraeruption of a dentoalveolar segment due to lack of occlusion;

(III) Transverse Discrepancies—

(a) Presence of a transverse skeletal discrepancy which is two (2) or more standard deviations from published norms; or

(b) Total bilateral maxillary palatal cusp to mandibular-fossa discrepancy of 4mm or greater, or a unilateral discrepancy of 3mm or greater, given normal axial inclination of the posterior teeth; or

(IV) Asymmetries—

(a) Anteroposterior, transverse, or lateral asymmetries greater than 3mm with concomitant occlusal asymmetry;

(V) Masticatory (chewing) and swallowing dysfunction due to malocclusion (e.g., inability to incise or chew solid foods, choking on incompletely masticated solid foods, damage to soft tissue during mastication, malnutrition);

(VI) Speech impairment; or

(VII) Obstructive sleep apnea or airway dysfunction;

/36./38. Orthotics.

A. Ankle-Foot Orthosis (AFO) and Knee-Ankle-Foot Orthosis (KAFO).

(I) Basic coverage criteria for AFO and KAFO used during ambulation are as follows:

(a) AFO is covered when used in ambulation for members with weakness or deformity of the foot and ankle, which require stabilization for medical reasons, and have the potential to benefit functionally;

(b) KAFO is covered when used in ambulation for members when the following criteria are met:

I. Member is covered for AFO; and

II. Additional knee stability is required; and

(c) AFO and KAFO that are molded-to-patient-model, or custom-fabricated, are covered when used in ambulation, only when the basic coverage criteria and one (1) of the following criteria are met:

I. The member could not be fitted with a prefabricated AFO;

II. AFO or KAFO is expected to be permanent or for more than six (6) months duration;

III. Knee, ankle, or foot must be controlled in more than one (1) plane;

IV. There is documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or

V. The member has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

(II) AFO and KAFO Not Used During Ambulation.

(a) AFO and KAFO not used in ambulation are covered

if the following criteria are met:

I. Passive range of motion test was measured with goniometer and documented in the medical record;

II. Documentation of an appropriate stretching program administered under the care of provider or caregiver;

III. Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least ten degrees (10°) (i.e., a non-fixed contracture);

IV. Reasonable expectation of the ability to correct the contracture;

V. Contracture is interfering or expected to interfere significantly with the patient's functional abilities; and

VI. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons; or

VII. Member has plantar fasciitis.

(b) Replacement interface for AFO or KAFO is covered only if member continues to meet coverage criteria and is limited to a maximum of one (1) per six (6) months.

B. Cast Boot, Post-Operative Sandal or Shoe, or Healing Shoe. A cast boot, post-operative sandal or shoe, or healing shoe is covered for one (1) of the following indications:

(I) To protect a cast from damage during weight-bearing activities following injury or surgery;

(II) To provide appropriate support and/or weight-bearing surface to a foot following surgery;

(III) To promote good wound care and/or healing via appropriate weight distribution and foot protection; or

(IV) When the patient is currently receiving treatment for lymphedema and the foot cannot be fitted into conventional footwear.

C. Cranial Orthoses. Cranial orthosis is covered for Synostotic and Non-Synostotic Plagiocephaly. Plagiocephaly is an asymmetrically shaped head. Synostotic Plagiocephaly is due to premature closure of cranial sutures. Non-Synostotic Plagiocephaly is from positioning or deformation of the head. Cranial orthosis is the use of a special helmet or band on the head which aids in molding the shape of the cranium to normal. Initial reimbursement shall cover any subsequent revisions.

D. Elastic Supports. Elastic supports are covered when prescribed for one (1) of the following indications:

(I) Severe or incapacitating vascular problems, such as acute thrombophlebitis, massive venous stasis, or pulmonary embolism;

(II) Venous insufficiency;

(III) Varicose veins;

(IV) Edema of lower extremities;

(V) Edema during pregnancy; or

(VI) Lymphedema.

E. Footwear Incorporated Into a Brace for Members with Skeletally Mature Feet. Footwear incorporated into a brace must be billed by the same supplier billing for the brace. The following types of footwear incorporated into a brace are covered:

(I) Orthopedic footwear;

(II) Other footwear such as high top, depth inlay, or custom;

(III) Heel replacements, sole replacements, and shoe transfers involving shoes on a brace;

(IV) Inserts for a shoe that is an integral part of a brace and are required for the proper functioning of the brace; or

(V) Other shoe modifications if they are on a shoe that is an integral part of a brace and are required for the proper functioning of the brace.

F. Foot Orthoses. Custom, removable foot orthoses are covered for members who meet the following criteria:

(I) Member with skeletally mature feet who has any of the following conditions:

(a) Acute plantar fasciitis;

(b) Acute sport-related injuries with diagnoses related to inflammatory problems such as bursitis or tendonitis;

(c) Calcaneal bursitis (acute or chronic);

(d) Calcaneal spurs (heel spurs);

(e) Conditions related to diabetes;

(f) Inflammatory conditions (e.g., sesamoiditis, sub-metatarsal bursitis, synovitis, tenosynovitis, synovial cyst, osteomyelitis, and plantar fascial fibromatosis);

(g) Medial osteoarthritis of the knee;

(h) Musculoskeletal/arthropathic deformities including deformities of the joint or skeleton that impairs walking in a normal shoe (e.g., bunions, hallux valgus, talipes deformities, pes deformities, or anomalies of toes);

(i) Neurologically impaired feet including neuroma, tarsal tunnel syndrome, ganglionic cyst;

(j) Neuropathies involving the feet, including those associated with peripheral vascular disease, diabetes, carcinoma, drugs, toxins, and chronic renal disease; or

(k) Vascular conditions including ulceration, poor circulation, peripheral vascular disease, Buerger's disease (thromboangiitis obliterans), and chronic thrombophlebitis;

(II) Member with skeletally immature feet who has any of the following conditions:

(a) Hallux valgus deformities;

(b) In-toe or out-toe gait;

(c) Musculoskeletal weakness such as pronation or pes planus;

(d) Structural deformities such as tarsal coalitions; or

(e) Torsional conditions such as metatarsus adductus, tibial torsion, or femoral torsion.

G. Helmets. Helmets are covered when cranial protection is required due to a documented medical condition that makes the member susceptible to injury during activities of daily living.

H. Hip Orthosis. Hip orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the hip;

(II) To facilitate healing following an injury to the hip or related soft tissues;

(III) To facilitate healing following a surgical procedure of the hip or related soft tissue; or

(IV) To otherwise support weak hip muscles or a hip deformity.

I. Knee Orthosis. Knee orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the knee;

(II) To facilitate healing following an injury to the knee or related soft tissues;

(III) To facilitate healing following a surgical procedure on the knee or related soft tissue; or

(IV) To otherwise support weak knee muscles or a knee deformity.

J. Orthopedic Footwear for Diabetic Members.

(I) Orthopedic footwear, therapeutic shoes, inserts, or modifications to therapeutic shoes are covered for diabetic members if any following criteria are met:

(a) Previous amputation of the other foot or part of either foot;

(b) History of previous foot ulceration of either foot;

(c) History of pre-ulcerative calluses of either foot;

(d) Peripheral neuropathy with evidence of callus formation of either foot;

(e) Foot deformity of either foot; or

(f) Poor circulation in either foot.

(II) Coverage is limited to one (1) of the following within one (1) year:

(a) One (1) pair of custom molded shoes (which includes inserts provided with these shoes) and two (2) additional pairs of inserts;

(b) One (1) pair of depth shoes and three (3) pairs of inserts (not including the non-customized removable inserts provided with such shoes); or

(c) Up to three (3) pairs of inserts not dispensed with

diabetic shoes if the supplier of the shoes verifies in writing that the patient has appropriate footwear into which the insert can be placed.

K. Orthotic-Related Supplies. Orthotic-related supplies are covered when necessary for the function of the covered orthotic device.

L. Spinal Orthoses. A thoracic-lumbar-sacral orthosis, lumbar orthosis, lumbar-sacral orthosis, and cervical orthosis are covered for the following indications:

- (I) To reduce pain by restricting mobility of the trunk;
- (II) To facilitate healing following an injury to the spine or related soft tissues;
- (III) To facilitate healing following a surgical procedure of the spine or related soft tissue; or
- (IV) To otherwise support weak spinal muscles or a deformed spine.

M. Trusses. Trusses are covered when a hernia is reducible with the application of a truss.

N. Upper Limb Orthosis. Upper limb orthosis is covered for the following indications:

- (I) To reduce pain by restricting mobility of the joint(s);
- (II) To facilitate healing following an injury to the joint(s) or related soft tissues; or
- (III) To facilitate healing following a surgical procedure of the joint(s) or related soft tissue.

O. Orthotic Device Replacement. When repairing an item that is no longer cost-effective and is out of warranty, the plan will consider replacing the item subject to review of medical necessity and life expectancy of the device;

[37./39. Preventive services.

A. Services recommended by the U.S. Preventive Services Task Force (categories A and B).

B. *[Immunizations]* **Vaccinations** recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

C. Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration.

D. Preventive care and screenings for women supported by the Health Resources and Services Administration.

E. Preventive exams and other services ordered as part of the exam. For benefits to be covered as preventive, *[including X-rays and lab services,]* they must be coded by the provider as routine, without indication of an injury or illness.

F. Cancer screenings. One (1) per calendar year. Additional screenings beyond one (1) per calendar year covered as diagnostic unless otherwise specified—

(I) Mammograms—no age limit. Standard two-dimensional (2D) breast mammography and breast tomosynthesis (three-dimensional (3D) mammography);

(II) Pap smears—no age limit;

(III) Prostate—no age limit; and

(IV) Colorectal screening—no age limit.

G. *[Zoster vaccination (shingles)—The zoster vaccine is covered for members age fifty (50) years and older]* **Online weight management program offered through the plan's exclusive provider arrangement;**

[38./40. Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement is covered due to normal wear and tear, if there is a change in medical condition, or if growth-related;

[39./41. Pulmonary rehabilitation. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and post-operative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

A. Member has a reduction of exercise tolerance that restricts the ability to perform activities of daily living (ADL) or work;

B. Member has chronic pulmonary disease (including asthma, emphysema, chronic bronchitis, chronic airflow obstruction, cystic fibrosis, alpha-1 antitrypsin deficiency, pneumoconiosis,

asbestosis, radiation pneumonitis, pulmonary fibrosis, pulmonary alveolar proteinosis, pulmonary hemosiderosis, fibrosing alveolitis), or other conditions that affect pulmonary function such as ankylosing spondylitis, scoliosis, myasthenia gravis, muscular dystrophy, Guillain-Barré syndrome, or other infective polyneuritis, sarcoidosis, paralysis of diaphragm, or bronchopulmonary dysplasia; and

C. Member has a moderate to moderately severe functional pulmonary disability, as evidenced by either of the following, and does not have any concomitant medical condition that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g., symptomatic coronary artery disease, congestive heart failure, myocardial infarction within the last six (6) months, dysrhythmia, active joint disease, claudication, malignancy):

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake (VO_2max) equal to or less than twenty milliliters per kilogram per minute (20 mL/kg/min), or about five (5) metabolic equivalents (METs); or

(II) Pulmonary function tests showing that either the Forced Expiratory Volume in One Second (FEV1), Forced Vital Capacity (FVC), FEV1/FVC, or Diffusing Capacity of the Lung for Carbon Monoxide (DLCO) is less than sixty percent (60%) of that predicted;

[40./42. Skilled Nursing Facility. Skilled nursing facility services are covered up to one hundred twenty (120) days per calendar year;

[41./43. Telehealth Services. Telehealth services are covered for the diagnosis, consultation, or treatment of a member on the same basis that the service would be covered when it is delivered in person;

[42./44. Therapy. Physical, occupational, and speech therapy are covered when prescribed by a provider and subject to the provisions below:

A. Physical therapy.

(I) Physical therapy must meet the following criteria:

(a) The program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, congenital defect, or surgery;

(b) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(c) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

B. Occupational therapy must meet the following criteria:

(I) The program is designed to improve or compensate for lost or impaired physical functions, particularly those affecting activities of daily living, resulting from illness, injury, congenital defect, or surgery;

(II) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(III) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

C. Speech therapy.

(I) All of the following criteria must be met for coverage of speech therapy:

(a) The therapy requires one-to-one intervention and supervision of a speech-language pathologist;

(b) The therapy plan includes specific tests and measures that will be used to document significant progress every two (2) weeks;

(c) Meaningful improvement is expected;

(d) The therapy includes a transition from one-to-one supervision to a self- or caregiver- provided maintenance program upon discharge; and

(e) One (1) of the following:

I. Member has severe impairment of speech-language; and an evaluation has been completed by a certified speech-language pathologist that includes age-appropriate standardized tests to measure the extent of the impairment, performance deviation, and language

and pragmatic skill assessment levels; or

II. Member has a significant voice disorder that is the result of anatomic abnormality, neurological condition, or injury (e.g., vocal nodules or polyps, vocal cord paresis or paralysis, post-operative vocal cord surgery);

[43.]45. Transplants. Stem cell, kidney, liver, heart, lung, pancreas, small bowel, or any combination are covered. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements.

A. Network includes travel and lodging allowance for the transplant recipient and an immediate family travel companion when the transplant facility is more than fifty (50) miles from the recipient's residence. If the recipient is younger than age nineteen (19) years, travel and lodging is covered for both parents. The transplant recipient must be with the travel companion or parent(s) for the travel companion's or parent(s)' travel expense to be reimbursable. Combined travel and lodging expenses are limited to a ten thousand dollar (\$10,000) maximum per transplant.

(I) Lodging—maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to www.gsa.gov for per diem rates.

(II) Travel—IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).

(III) Meals—not covered.

B. Non-network. Charges above the maximum for services rendered at a non-network facility are the member's responsibility and do not apply to the member's deductible or out-of-pocket maximum. Travel, lodging, and meals are not covered;

[44.]46. Urgent care. Member encounter with a provider for urgent care is covered based on the service, procedure, or related treatment plan; and

[45.]47. Vision. One (1) routine exam and refraction is covered per calendar year.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Amended: Filed Oct. 31, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 2—State Membership

PROPOSED RESCISSION

22 CSR 10-2.060 PPO 300 Plan, PPO 600 Plan, and Health Savings Account Plan Limitations. This rule established the policy of the board of trustees in regard to the PPO 300 Plan, PPO 600

Plan, and Health Savings Account (HSA) Plan limitations of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded because the PPO 300 and PPO 600 Plans will not be offered after December 31, 2018.

AUTHORITY: sections 103.059 and 103.080.3., RSMo 2016. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the **Code of State Regulations**. Emergency rescission filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Rescinded: Filed Oct. 31, 2018.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 2—State Membership

PROPOSED RULE

22 CSR 10-2.061 Plan Limitations

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 750 Plan, PPO 1250 Plan, and Health Savings Account (HSA) Plan limitations of the Missouri Consolidated Health Care Plan.

(1) Benefits shall not be payable for, or in connection with, any medical benefits, services, or supplies which do not come within the definition of covered charges. In addition, the items specified in this rule are not covered unless expressly stated otherwise and then only to the extent expressly provided herein or in 22 CSR 10-2.055 or 22 CSR 10-2.090.

(A) Abortion—unless the life of the mother is endangered if the fetus is carried to term or due to death of the fetus.

(B) Acts of war including—injury or illness caused, or contributed to, by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.

(C) Alternative therapies—that are outside conventional medicine including, but not limited to, acupuncture, acupressure, homeopathy, hypnosis, massage therapy, reflexology, and biofeedback.

(D) Assistive listening device.

(E) Assistant surgeon services—unless determined to meet the clinical eligibility for coverage under the plan.

(F) Athletic enhancement services and sports performance training.

(G) Autopsy.

(H) Birthing center.

(I) Blood donor expenses.

(J) Blood pressure cuffs/monitors.

(K) Care received without charge.

(L) Charges exceeding the vendor contracted rate or benefit limit.

(M) Charges resulting from the failure to appropriately cancel a scheduled appointment.

(N) Childbirth classes.

(O) Comfort and convenience items.

(P) Cosmetic procedures.

(Q) Custodial or domiciliary care—including services and supplies that assist members in the activities of daily living such as walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet; preparation of special diets; supervision of medication that is usually self-administered; or other services that can be performed by persons who are not providers.

(R) Dental care, including oral surgery.

(S) Devices or supplies bundled as part of a service are not separately covered.

(T) Dialysis received through a non-network provider.

(U) Educational or psychological testing unless part of a treatment program for covered services.

(V) Examinations requested by a third party.

(W) Exercise equipment.

(X) Experimental/investigational/unproven services, procedures, supplies, or drugs as determined by the claims administrator.

(Y) Eye services and associated expenses for orthoptics, eye exercises, radial keratotomy, LASIK, and other refractive eye surgery.

(Z) Genetic testing based on family history alone, except for breast cancer susceptibility gene (BRCA) testing.

(AA) Health and athletic club membership—including costs of enrollment.

(BB) Hearing aid replacement batteries.

(CC) Home births.

(DD) Infertility treatment beyond the covered services to diagnose the condition.

(EE) Infusions received through a non-network provider.

(FF) Level of care, greater than is needed for the treatment of the illness or injury.

(GG) Long-term care.

(HH) Maxillofacial surgery.

(II) Medical care and supplies to the extent that they are payable under—

1. A plan or program operated by a national government or one (1) of its agencies; or

2. Any state's cash sickness or similar law, including any group insurance policy approved under such law.

(JJ) Medical service performed by a family member—including a person who ordinarily resides in the subscriber's household or is related to the member, such as a spouse, parent, child, sibling, or brother/sister-in-law.

(KK) Military service-connected injury or illness—including expenses relating to Veterans Affairs or a military hospital.

(LL) Never events—never events on a list compiled by the National Quality Forum of inexcusable outcomes in a health care setting.

(MM) Nocturnal enuresis alarm.

(NN) Drugs that the pharmacy benefit manager (PBM) has excluded from the formulary and will not cover as a non-formulary drug unless it is approved in advance by the PBM.

(OO) Non-medically necessary services.

(PP) Non-provider allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning.

(QQ) Non-reusable disposable supplies.

(RR) Online weight management programs.

(SS) Other charges as follows:

1. Charges that would not otherwise be incurred if the subscriber was not covered by the plan;

2. Charges for which the subscriber or his/her dependents are not legally obligated to pay including, but not limited to, any portion of any charges that are discounted;

3. Charges made in the subscriber's name but which are actually due to the injury or illness of a different person not covered by the

plan; and

4. No coverage for miscellaneous service charges including, but not limited to, charges for telephone consultations, administrative fees such as filling out paperwork or copy charges, or late payments.

(TT) Over-the-counter medications with or without a prescription including, but not limited to, analgesics, antipyretics, non-sedating antihistamines, unless otherwise covered as a preventive service.

(UU) Physical and recreational fitness.

(VV) Private-duty nursing.

(WW) Routine foot care without the presence of systemic disease that affects lower extremities.

(XX) Services obtained at a government facility if care is provided without charge.

(YY) Sex therapy.

(ZZ) Surrogacy—pregnancy coverage is limited to plan member.

(AAA) Telehealth site origination fees or costs for the provision of telehealth services are not covered.

(BBB) Therapy. Physical, occupational, and speech therapy are not covered for the following:

1. Physical therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Physical therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

E. Work hardening programs;

F. Back school;

G. Vocational rehabilitation programs and any program with the primary goal of returning an individual to work;

H. Group physical therapy (because it is not one-on-one, individualized to the specific person's needs); or

I. Services for the purpose of enhancing athletic or sports performance;

2. Occupational therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Occupational therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., physical therapy);

E. Work hardening programs;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Group occupational therapy (because it is not one-on-one, individualized to the specific person's needs); and

H. Driving safety/driver training; and

3. Speech or voice therapy—

A. Any computer-based learning program for speech or voice training purposes;

B. School speech programs;

C. Speech or voice therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

D. Group speech or voice therapy (because it is not one-on-one, individualized to the specific person's needs);

E. Maintenance programs of routine, repetitive drills/exercises that do not require the skills of a speech-language therapist and that can be reinforced by the individual or caregiver;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Therapy or treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

H. Therapy or treatment provided to improve or enhance job, school, or recreational performance; and

I. Long-term rehabilitative services when significant therapeutic improvement is not expected.

(CCC) Travel expenses.

(DDD) Vaccinations requested by third party.

(EEE) Workers' Compensation services or supplies for an illness or injury eligible for, or covered by, any federal, state, or local government Workers' Compensation Act, occupational disease law, or other similar legislation.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Original rule filed Oct. 31, 2018.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

PROPOSED AMENDMENT

22 CSR 10-2.075 Review and Appeals Procedure. The Missouri Consolidated Health Care Plan is amending sections (1), (2), (3), (5), and (6).

PURPOSE: This amendment revises the names of the medical plans and clarifies general appeal provisions, the appeals process for Medicare members, and documentation requirements when submitting an appeal to add dependents.

(1) Claims Submissions and Initial Benefit Determinations [for Medical and Non-Medicare Primary Pharmacy Services] **PPO 750 Plan, PPO 1250 Plan, and Health Savings Account (HSA) Plan members.**

(2) General Appeal Provisions [for Medical and Non-Medicare Primary Pharmacy Services].

(3) Appeal Process for Medical and Pharmacy Determinations for **PPO 750 Plan, PPO 1250 Plan, and Health Savings Account (HSA) Plan members.**

(5) In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines. **Decisions concerning eligibility for Medicare primary members may not be able to be granted pursuant to these guidelines if the decision is contrary to the rules controlling eligibility for Medicare Advantage plan as put forth by Centers for Medicare and Medicaid. Valid proof of eligibility must be included with the appeal if the enrollment request includes addition of dependent(s).** Payment in full for all past and current premiums due for enrollment requests must be included with the appeal if it cannot be collected through payroll deduction:

(A) If a subscriber currently has coverage under the plan, MCHCP may approve the subscriber's request to enroll his/her newborn or the newborn of an enrolled dependent retroactively to the date of birth if the appeal is received within three (3) months of the child's birth date. *Valid proof of eligibility must be included with the appeal*;

(6) Medicare [Primary Pharmacy] Appeals.

(B) Appeals rights and procedures for benefits covered by the Medicare Advantage Plan are provided as regulated by the Centers for Medicare and Medicaid Services. Members may contact the Medicare Advantage Plan for additional rights and procedures.

(C) Administrative Appeals as specified in subsection (3)(B) of this rule shall follow the procedures set forth in that subsection.

AUTHORITY: section 103.059, RSMo [2000] 2016. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Amended: Filed Oct. 31, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

PROPOSED AMENDMENT

22 CSR 10-2.080 Miscellaneous Provisions. The Missouri Consolidated Health Care Plan is amending section (5).

PURPOSE: This amendment revises the names of the medical plans.

(5) The PPO [300] 750 Plan, PPO [600] 1250 Plan, and Health Savings Account Plan benefits including pharmacy are self-funded by the plan. MCHCP has subrogation rights under section 376.433, RSMo for any amounts expended for these benefits.

AUTHORITY: section 103.059, RSMo [2000] 2016. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Amended: Filed Oct. 31, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in

support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

PROPOSED RULE

22 CSR 10-2.088 Medicare Advantage Plan for Non-Active Medicare Primary Members

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Medicare Advantage Plan for Non-active Medicare-primary members of the Missouri Consolidated Health Care Plan.

(1) The medical benefit for non-Active Medicare primary members is provided through a fully-insured Group Medicare Advantage PPO Plan as regulated by the Centers for Medicare and Medicaid Services (CMS) herein after referred to as the Medicare Advantage Plan. For purposes of this rule non-Active Medicare primary members include: Medicare-eligible members who are eligible retirees, terminated vested subscribers, long-term disability subscribers, and their eligible dependents who have Medicare.

(A) Members must be enrolled in Medicare Parts A and B to be eligible for the Medicare Advantage Plan.

(B) Non-active subscribers that have Medicare and/or their dependents that have Medicare shall receive their medical benefit through the Medicare Advantage Plan.

(C) Subscribers enrolled in the Medicare Advantage Plan will choose another medical plan offered by MCHCP for their non-Medicare dependents.

(D) Beginning the first day of the month in which a non-active Medicare primary member turns sixty-five (65) years old, they shall be transferred to the Medicare Advantage Plan.

(E) A member who opts out of the Medicare Advantage Plan will lose MCHCP eligibility and will not be allowed to enroll in a medical plan at a later date unless otherwise provided for in these rules.

(2) The Medicare Advantage Plan design is defined by the vendor, including deductible, out-of-pocket maximum, and benefits covered. Benefits shall be substantially similar to the benefits offered to non-Medicare members.

(3) The Medicare Advantage Plan eligibility, enrollment, and termination requirements are determined by the plan administrator and are defined in 22 CSR 10-2.020, and in conjunction with the rules set forth by CMS.

(4) Appeals.

(A) Appeals concerning claims and benefits are managed by the vendor in accordance with CMS rules.

(B) Administrative appeals concerning eligibility and termination are managed by MCHCP in accordance with 22 CSR 10-2.075.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Original rule filed Oct. 31, 2018.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

PROPOSED AMENDMENT

22 CSR 10-2.089 Pharmacy Employer Group Waiver Plan for Medicare Primary Members. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment clarifies eligibility for the Pharmacy Employer Group Waiver Plan, the Part B drug benefit, and preventive drugs; updates the Medicare Part D coverage stage and the copayment amounts; and removes language regarding the Medicare Prescription Drug Only Plan.

(1) The pharmacy benefit for Medicare primary **non-active** members is provided through a Pharmacy Employer Group Waiver Plan (EGWP) as regulated by the Centers for Medicare and Medicaid Services herein after referred to as the Medicare Prescription Drug Plan.

(A) *[The following Medicare primary members] Non-active subscribers that have Medicare primary coverage and their dependents that have Medicare primary coverage* enrolled in *[the PPO 300, PPO 600, or] the Medicare [Prescription Drug Only] Advantage Plan* shall receive their pharmacy benefit through the Medicare Prescription Drug Plan~~[/].~~

[1. Active employee members that have Medicare primary coverage and their dependents that have Medicare primary coverage; and

2. Retiree members that have Medicare primary coverage and their dependents that have Medicare primary coverage.]

(B) The non-Medicare *[primary]* dependents of Medicare primary *[members] non-active subscribers* will not be in the Medicare Prescription Drug Plan but will have pharmacy benefit coverage as defined by 22 CSR 10-2.090.

(F) The Medicare Prescription Drug Plan is comprised of a Medicare Part D prescription drug plan contracted by MCHCP and some non-Part D medications that are not normally covered by a Medicare Part D prescription drug plan. The requirements for the Medicare Part D prescription drug plan are as follows:

1. The Centers for Medicare and Medicaid Services regulates the Medicare Part D prescription drug program. The Medicare Prescription Drug Plan abides by those regulations;

2. Initial Coverage Stage. Until a member's total yearly Part D prescription drug costs reach *[three thousand seven hundred fifty dollars (\$3,750)] three thousand eight hundred twenty dollars (\$3,820)*, the member will pay the following copayments:

A. Preferred Formulary Generic Drugs: thirty-one- (31-) day supply has *[an eight dollar (\$8)] a ten dollar (\$10)* copayment; sixty- (60-) day supply has a *[sixteen dollar (\$16)] twenty dollar (\$20)* copayment; ninety- (90-) day supply at retail has a *[twenty-four dollar (\$24)] thirty dollar (\$30)* copayment; and a ninety- (90-) day supply through home delivery has a *[twenty dollar (\$20)] twenty-five dollar (\$25)* copayment;

B. Preferred Formulary Brand Drugs: thirty-one- (31-) day supply has a *[thirty-five dollar (\$35)]* **forty dollar (\$40)** copayment; sixty- (60-) day supply has *[a seventy dollar (\$70)]* **an eighty (\$80) dollar** copayment; ninety- (90-) day supply at retail has *[a one hundred five dollar (\$105)]* **one hundred twenty (\$120) dollar** copayment; and a ninety- (90-) day supply through home delivery has *[an eighty-seven dollar and fifty cent (\$87.50)]* **a one hundred (\$100) dollar** copayment; and

C. Non-preferred Formulary Drugs and approved excluded drugs: thirty-one- (31-) day supply has a one hundred dollar (\$100) copayment; sixty- (60-) day supply has a two hundred dollar (\$200) copayment; ninety- (90-) day supply at retail has a three hundred dollar (\$300) copayment; and a ninety- (90-) day supply through home delivery has a two hundred fifty dollar (\$250) copayment;

3. Coverage Gap Stage. After a member's total yearly Part D prescription drug costs exceed *[three thousand seven hundred fifty dollars (\$3,750)]* **three thousand eight hundred twenty dollars (\$3,820)** and remain below *[five thousand dollars (\$5,000)]* **five thousand one hundred dollars (\$5,100)**, the member will continue to pay the same cost-sharing amount as in the Initial Coverage stage until the yearly out-of-pocket Part D prescription drug costs reach *[five thousand dollars (\$5,000)]* **five thousand one hundred dollars (\$5,100)**;

4. Catastrophic Coverage Stage. After a member's total yearly out-of-pocket Part D prescription drug costs reach *[five thousand dollars (\$5,000)]* **five thousand one hundred dollars (\$5,100)**, the member will pay the greater of—

A. Five percent (5%) coinsurance or a *[three dollar and thirty-five cent (\$3.35)]* **three dollar and forty cent (\$3.40)** copayment for covered generic drugs (including brand drugs treated as generics), with a maximum not to exceed the standard copayment during the Initial Coverage stage; or

B. Five percent (5%) coinsurance or an *[eight dollar and thirty-five cent (\$8.35)]* **eight dollar and fifty cent (\$8.50)** copayment for all other covered drugs, with a maximum not to exceed the standard copayment during the Initial Coverage stage; and

5. Amounts paid by the member or the plan for non-Part D prescription drugs will not count toward total Part D prescription drug costs or total Part D prescription drug out-of-pocket costs; and/.

[6. Medicare Prescription Drug Only Plan. Medicare retirees have the option of choosing the Medicare Prescription Drug Plan for coverage for prescription drugs only, without MCHCP medical coverage.]

(H) Medicare Part B Prescription Drugs are excluded from the **Medicare Prescription Drug Plan**. *[For covered Medicare Part B prescriptions, Medicare and MCHCP will coordinate to provide up to one hundred percent (100%) coverage for the drugs. To receive Medicare Part B prescriptions without a copayment or coinsurance, the subscriber must submit prescriptions and refills to a Medicare Part B contracted retail pharmacy which is in the pharmacy benefit manager (PBM) network. Medicare Part B prescriptions include, but are not limited to, the following:]*

- [1. Diabetes testing and maintenance supplies;*
- 2. Respiratory agents;*
- 3. Immunosuppressants; and*
- 4. Oral anti-cancer medications.]*

(I) Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S Preventive Services Task Force (categories A and B) are covered at one hundred percent (100%) when filled at a network pharmacy. The following are also covered at one hundred percent (100%) when filled at a network pharmacy:

- [1. Prescribed Vitamin D for all ages:*

A. The dosage range for preventive Vitamin D at or below 1000 IU of Vitamin D₂ or D₃ per dose;

2. Zoster (shingles) vaccine and administration for members age fifty (50) years and older;]

[3.]1. [Influenza v/Vaccines and administration as recommended by the Advisory Committee on Immunization Practices of

the Centers for Disease Control and Prevention; and

[4.]2. Preferred formulary brand contraception and non-preferred contraception when the provider determines a generic is not medically appropriate or a generic version is not available.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 30, 2013, effective Jan. 1, 2014, expired June 29, 2014. Original rule filed Oct. 30, 2013, effective June 30, 2014. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Amended: Filed Oct. 31, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN

Division 10—Health Care Plan

Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.090 Pharmacy Benefit Summary. The Missouri Consolidated Health Care Plan is amending the purpose and section (1).

PURPOSE: This amendment revises the names of the medical plans, copayments, preventive drugs, and out-of-pocket maximum.

PURPOSE: This rule establishes the policy of the board of trustees in regard to the benefit provisions, covered charges, limitations, and exclusions of the pharmacy benefit for the [PPO 300, PPO 600] PPO 750 Plan, PPO 1250 Plan, and Health Savings Account Plan of the Missouri Consolidated Health Care Plan.

(1) The pharmacy benefit provides coverage for prescription drugs. Vitamin and nutrient coverage is limited to prenatal agents, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents as prescribed by a provider to non-Medicare primary members.

(A) PPO [300] 750 Plan and PPO [600] 1250 Plan.

1. Network:

A. Preferred formulary generic drug copayment: *[Eight dollars (\$8)]* **Ten Dollars (\$10)** for up to a thirty-one- (31-) day supply; *[sixteen dollars (\$16)]* **twenty dollars (\$20)** for up to a sixty- (60-) day supply; and *[twenty-four dollars (\$24)]* **thirty dollars (\$30)** for up to a ninety- (90-) day supply for a generic drug on the formulary;

B. Preferred formulary brand drug copayment: *[Thirty-five dollars (\$35)]* **Forty dollars (\$40)** for up to a thirty-one- (31-) day supply; *[seventy dollars (\$70)]* **eighty dollars (\$80)** for up to a sixty- (60-) day supply; and *[one hundred and five dollars (\$105)]* **one hundred twenty dollars (\$120)** for up to a ninety- (90-) day supply for a brand drug on the formulary;

C. Non-preferred formulary drug and approved excluded drug copayment: One hundred dollars (\$100) for up to a thirty-one- (31-) day supply;

day supply; two hundred dollars (\$200) for up to a sixty- (60-) day supply; and three hundred dollars (\$300) for up to a ninety- (90-) day supply for a drug not on the formulary;

D. Specialty drug copayment: Seventy-five dollars (\$75) for up to a thirty-one- (31-) day supply for a specialty drug on the formulary;

[D./E. Diabetic drug (as designated as such by the PBM) copayment: fifty percent (50%) of the applicable network copayment;

[E./F. Home delivery programs.

(I) Maintenance prescriptions may be filled through the pharmacy benefit manager's (PBM's) home delivery program. A member must choose how maintenance prescriptions will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

(a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision and the amount charged will not apply to the out-of-pocket maximum.

(b) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM.

(II) Specialty drugs are covered only through the specialty home delivery network for up to a thirty-one- (31-) day supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. All specialty prescriptions must be filled through the PBM's specialty pharmacy, unless the prescription is identified by the PBM as emergent. The first fill of a specialty prescription identified to be emergent, may be filled through a retail pharmacy.

(a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply and charged a prorated copayment. If the member is able to continue with the medication, the remaining supply will be shipped and the member will be charged the remaining portion of the copayment. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment.

(III) Prescriptions filled through home delivery programs have the following copayments:

(a) Preferred formulary generic drug copayments: **[Eight dollars (\$8)] Ten dollars (\$10)** for up to a thirty-one- (31-) day supply; **[sixteen dollars (\$16)] twenty dollars (\$20)** for up to a sixty- (60-) day supply; and **[twenty dollars (\$20)] twenty-five dollars (\$25)** for up to a ninety- (90-) day supply for a generic drug on the formulary;

(b) Preferred formulary brand drug copayments: **[Thirty-five dollars (\$35)] Forty dollars (\$40)** for up to a thirty-one- (31-) day supply; **[seventy dollars (\$70)] eighty dollars (\$80)** for up to a sixty- (60-) day supply; and **[eighty-seven dollars and fifty cents (\$87.50)] one hundred dollars (\$100)** for up to a ninety- (90-) day supply for a brand drug on the formulary;

(c) Non-preferred formulary drug and approved excluded drug copayments: One hundred dollars (\$100) for up to a thirty-one- (31-) day supply; two hundred dollars (\$200) for up to a sixty- (60-) day supply; and two hundred fifty dollars (\$250) for up to a ninety- (90-) day supply for a drug not on the formulary;

(d) **Specialty drug copayment: Seventy-five dollars (\$75) for up to a thirty-one- (31-) day supply; one hundred fifty dollars (\$150) for up to sixty (60-) day supply; and two hundred twenty-five (\$225) for up to ninety- (90-) day supply for a specialty drug on the formulary;**

[F./G. Diabetic drug (as designated as such by the PBM)

copayment: fifty percent (50%) of the applicable network copayment;

[G./H. Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount;

[H./I. The copayment for a compound drug is based on the primary drug in the compound. The primary drug in a compound is the most expensive prescription drug in the mix. If any ingredient in the compound is excluded by the plan, the compound will be denied;

[I./J. If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug;

[J./K. If the physician allows for generic substitution and the member chooses a brand-name drug, the member is responsible for the generic copayment and the cost difference between the brand-name and generic drug which shall not apply to the out-of-pocket maximum;

L. Preferred select brand drugs, as determined by the PBM: Ten dollars (\$10) for up to a thirty-one- (31-) day supply; twenty dollars (\$20) for up to a sixty- (60-) day supply; and twenty-five dollars (\$25) for up to a ninety- (90-) day supply; and

[K./M. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy. The following are also covered at one hundred percent (100%) when filled at a network pharmacy:

[(I)] Prescribed Vitamin D for all ages;

(a) The dosage range for preventive Vitamin D at or below 1000 IU of Vitamin D₂ or D₃ per dose;

[(II)] Zoster (shingles) vaccine and administration for members age fifty (50) years and older;

[(III)](I) [Influenza v]accine [and administration as] recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

[(IV)](II) Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer;

[(V)](III) Prescribed preferred diabetic test strips and lancets; and

[(VI)](IV) One (1) preferred glucometer.

2. Non-network: If a member chooses to use a non-network pharmacy for non-specialty prescriptions, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable network copayment.

3. Out-of-pocket maximum.

A. Network and non-network out-of-pocket maximums are separate.

B. The family out-of-pocket maximum is an aggregate of applicable charges received by all covered family members of the plan. Any combination of covered family member applicable charges may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.

C. **Network [(I)]individual—[five thousand one hundred dollars (\$5,100)] four thousand one hundred fifty dollars (\$4,150).**

D. **Network [(F)]family—[ten thousand two hundred dollars (\$10,200)] eight thousand three hundred dollars (\$8,300).**

E. Non-network—no maximum.

(B) Health Savings Account (HSA) Plan Prescription Drug Coverage. Medical and pharmacy expenses are combined to apply toward the appropriate network or non-network deductible and out-of-pocket maximum specified in 22 CSR 10-2.053.

1. Network:

A. Preferred formulary generic drug: Ten percent (10%) coinsurance after deductible has been met for a generic drug on the formulary;

B. Preferred formulary brand drug: Twenty percent (20%)

coinsurance after deductible has been met for a brand drug on the formulary;

C. Non-preferred formulary drug and approved excluded drug: Forty percent (40%) coinsurance after deductible has been met;

D. Diabetic drug (as designated as such by the PBM) coinsurance: fifty percent (50%) of the applicable network coinsurance after deductible has been met;

E. Home delivery programs.

(I) Maintenance prescriptions may be filled through the PBM's home delivery program. A member must choose how maintenance prescriptions will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

(a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision.

(b) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM.

(II) Specialty drugs are covered only through the specialty home delivery network for up to a thirty-one- (31-) day supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. All specialty prescriptions must be filled through the PBM's specialty pharmacy, unless the prescription is identified by the PBM as emergent. The first fill of a specialty prescription identified to be emergent, may be filled through a retail pharmacy.

(a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply. If the member is able to continue with the medication, the remaining supply will be shipped. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment;

F. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy. The following are also covered at one hundred percent (100%) when filled at a network pharmacy:

[(II)] Prescribed Vitamin D for all ages;

(a) The dosage range for preventive Vitamin D is at or below 1000 IU of Vitamin D₂ or D₃ per dose;

[(II)] Zoster (shingles) vaccine and administration for members age fifty (50) years and older;

[(III)](I) Influenza v/Vaccines and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

[(IV)](II) Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer;

G. The following are covered at one hundred percent (100%) after deductible is met and when filled at a network pharmacy:

(I) Prescribed preferred diabetic test strips and lancets; and

(II) One (1) preferred glucometer;

H. If any ingredient in a compound drug is excluded by the plan, the compound will be denied.

2. Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable deductible or coinsurance.

A. Preferred formulary generic drug: Forty percent (40%)

coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a generic drug on the formulary.

B. Preferred formulary brand drug: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a brand drug on the formulary.

C. Non-preferred formulary drug and approved excluded drug: Fifty percent (50%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a drug not on the formulary.

D. Diabetic drug (as designated as such by the PBM) coinsurance: fifty percent (50%) of the applicable non-network coinsurance after deductible has been met.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2005, effective Jan. 1, 2006, expired June 29, 2006. Original rule filed Dec. 22, 2005, effective June 30, 2006. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Amended: Filed Oct. 31, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN

Division 10—Health Care Plan Chapter 2—State Membership

PROPOSED AMENDMENT

22 CSR 10-2.110 General Foster Parent Membership Provisions. The Missouri Consolidated Health Care Plan is amending sections (2), (3), and (5).

PURPOSE: This amendment revises foster parent eligibility requirements, enrollment procedures, enrollment of a newborn child proof of eligibility procedures, and disabled dependent documentation timeframes.

(2) Eligibility Requirements.

(B) Dependent Coverage. Eligible dependents include:

1. Spouse. If both spouses are eligible foster parents, each spouse must enroll separately;
2. Children.

A. Children may be covered through the end of the month in which they turn twenty-six (26) years old if they meet one (1) of the following criteria:

(I) Natural child of subscriber or spouse;

(II) Legally-adopted child of subscriber or spouse;

(III) Child legally placed for adoption of subscriber or spouse;

(IV) Stepchild of subscriber. Such child will continue to be considered a dependent after the stepchild relationship ends due to the death of the child's natural parent and subscriber's spouse;

(V) Foster child of subscriber or spouse. Such child will continue to be considered a dependent after the foster child relationship ends by operation of law when the child ages out if the foster child relationship between the subscriber or spouse and the child was in effect the day before the child ages out;

(VI) Grandchild for whom the subscriber or spouse has legal guardianship or legal custody;

(VII) A child for whom the subscriber or spouse is the court-ordered legal guardian under a guardianship of a minor. Such child will continue to be considered a dependent after the guardianship ends by operation of law when the child becomes eighteen (18) years old if the guardianship of a minor relationship between the subscriber or spouse and the child was in effect the day before the child became eighteen (18) years old;

(VIII) **[Newborn] Child of a dependent [or] as long as the parent is a dependent on the newborn's date of birth. The dependent and the child of the dependent must remain continuously covered on the plan for the child of the dependent to remain eligible;**

(IX) **[c]Child of a dependent when paternity by the dependent is established after birth [so] as long as the parent is a dependent on [the newborn's day of birth or] the date the child's paternity was established [and continues to be covered as a dependent of the subscriber] The dependent and the child of the dependent must remain continuously covered on the plan for the child of the dependent to remain eligible; or**

[(IX)](X) Child for whom the subscriber or spouse is required to provide coverage under a Qualified Medical Child Support Order (QMCSO).

B. A child who is twenty-six (26) years old or older and is permanently disabled in accordance with subsection (5)(C) may be covered only if such child was disabled the day before the child turned twenty-six (26) years old and has remained continuously disabled.

C. A child may only be covered by one (1) parent if his/her parents are married to each other and are both covered under an MCHCP medical plan.

D. A child may have dual coverage if the child's parents are divorced or have never married, and both have coverage under an MCHCP medical plan. MCHCP will only pay for a service once, regardless of whether the claim for the child's care is filed under multiple subscribers' coverage. If a child has coverage under two (2) subscribers, the child will have a separate deductible, copayment, and coinsurance under each subscriber. The claims administrator will process the claim and apply applicable cost-sharing using the coverage of the subscriber who files the claim first. The second claim for the same services will not be covered. If a provider files a claim simultaneously under both subscribers' coverage, the claim will be processed under the subscriber whose birthday is first in the calendar year. If both subscribers have the same birthday, the claim will be processed under the subscriber whose coverage has been in effect for the longest period of time; or

3. Changes in dependent status. If a dependent loses his/her eligibility, the subscriber must notify MCHCP within thirty-one (31) days of the loss of eligibility. Coverage will end on the last day of the month that the completed form is received by MCHCP or the last day of the month MCHCP otherwise receives credible evidence of loss of eligibility under the plan.

(3) Enrollment Procedures.

(C) An eligible foster parent may **[apply for] elect or change** coverage for himself/herself and/or for his/her spouse/child(ren) if one (1) of the following occurs:

1. Occurrence of a life event, which includes marriage, birth, adoption, and placement of child(ren). A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the eligible foster parent's responsibility to notify MCHCP of the life event;

A. If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

2. Employer-sponsored group coverage loss. An eligible foster parent **[and] or** his/her spouse/child(ren) may enroll within sixty (60) days **[if s/he involuntarily loses] due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances:**

A. Employer-sponsored medical, dental, or vision plan terminates;

B. Eligibility for employer-sponsored coverage ends;

C. Employer contributions toward the premiums end; or

D. Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage ends; or

3. If an eligible foster parent or his/her spouse/child(ren) loses MO HealthNet or Medicaid status, s/he may enroll in an MCHCP plan within sixty (60) days of the date of loss; or

4. If an eligible foster parent or eligible foster parent's spouse receives a court order stating s/he is responsible for covering a child, the eligible foster parent may enroll the child in an MCHCP plan within sixty (60) days of the court order; or

5. Default Enrollment

[5].A. If an eligible foster parent is enrolled in the PPO 300 or PPO 600 Plan and does not complete enrollment during the open enrollment period, the foster parent and his/her dependents will be enrolled at the same level of coverage in the PPO **[600] 1250** Plan provided through the vendor the foster parent is enrolled in, effective the first day of the next calendar year; or

[6].B. If an eligible foster parent is enrolled in the Health Savings Account (HSA) Plan and does not complete enrollment during the open enrollment period, the foster parent and his/her dependents will be enrolled at the same level of coverage in the HSA Plan provided through the vendor the foster parent is enrolled in, effective the first day of the next calendar year;

[7].C. If an eligible foster parent is enrolled in dental and/or vision coverage and does not complete open enrollment to cancel coverage or change the current level of coverage during the open enrollment period, the foster parent and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year; or

[8].6. If an eligible foster parent submits an Open Enrollment Worksheet or an Enroll/Change/Cancel form that is incomplete or contains obvious errors, MCHCP will notify the foster parent of such by mail, phone, or secure message. The foster parent must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date MCHCP notifies the foster parent, whichever is later.

(5) Proof of Eligibility. Proof of eligibility documentation is required for all dependents and subscribers, as necessary. Enrollment is not complete until proof of eligibility is received by MCHCP. A subscriber must include his/her MCHCPid or Social Security number on the documentation. If proof of eligibility is not received, MCHCP will send a letter requesting it from the subscriber. Except for open enrollment, documentation must be received within thirty-one (31) days of the date MCHCP processed the enrollment, or coverage will not take effect for those individuals whose proof of eligibility was not received. MCHCP reserves the right to request that such proof of eligibility be provided at any time upon request. If such proof is not

received or is unacceptable as determined by MCHCP, coverage will terminate or never take effect. If enrolling during open enrollment, proof of eligibility must be received by November 20, or coverage will not take effect the following January 1 for those individuals whose proof of eligibility was not received. If invalid proof of eligibility is received, the subscriber is allowed an additional ten (10) days from the initial due date to submit valid proof of eligibility.

(A) When enrolling a newborn **child**, the *[member]* **subscriber** must notify MCHCP of the birth verbally or in writing within thirty-one (31) days of the birth date. MCHCP will then send an enrollment form and letter notifying the *[member]* **subscriber** of the steps to initiate coverage. The *[member]* **subscriber** is allowed an additional ten (10) days from the date of the plan notice to return the enrollment form. Coverage will not begin unless the enrollment form is received within thirty-one (31) days of the birth date or ten (10) days from the date of the notice, whichever is later. Newborn proof of eligibility must be submitted within ninety (90) days of the birth date. If proof of eligibility is not received, coverage will terminate on day ninety-one (91) from the birth date.

(E) Disabled Dependent.

1. A newly eligible foster parent may enroll his/her permanently disabled child or an enrolled permanently disabled dependent turning age twenty-six (26) years, may continue coverage beyond age twenty-six (26) years, provided the following documentation is submitted to the plan prior to the **end of the month of the** dependent's twenty-sixth birthday for the enrolled permanently disabled dependent or within thirty-one (31) days of enrollment of a new foster parent and his/her permanently disabled child:

A. Evidence from the Social Security Administration (SSA) that the permanently disabled dependent or child was entitled to and receiving disability benefits prior to turning age twenty-six (26) years; and

B. A benefit verification letter dated within the last twelve (12) months from the SSA confirming the child is still considered disabled.

2. If a disabled dependent over the age of twenty-six (26) years is determined to be no longer disabled by the SSA, coverage will terminate the last day of the month in which the disability ends or never take effect for new enrollment requests.

3. Once the disabled child's coverage is cancelled or terminated, s/he will not be able to enroll at a later date.

AUTHORITY: sections 103.059 and 103.078, RSMo 2016. Emergency rule filed Aug. 28, 2012, effective Oct. 1, 2012, terminated Feb. 27, 2013. Original rule filed Aug. 28, 2012, effective Feb. 28, 2013. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Amended: Filed Oct. 31, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

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**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership**

PROPOSED AMENDMENT

22 CSR 10-2.140 Strive for Wellness® Health Center Provisions, Charges, and Services. The Missouri Consolidated Health Care Plan is amending sections (2) and (4).

PURPOSE: This amendment clarifies available services and preventive services; and revises the names of the medical plans.

(2) Available Services. The health center provides access to treatment for uncomplicated minor illnesses and to preventive health care services including, but not limited to, the following:

(I) *[Immunizations]* **Vaccinations** including *[immunization for]* influenza **vaccine**;

(O) Ordinary and routine care of the nature of a visit to the *[doctor's]* **health care provider's** office; and

(4) Charges for the following services apply:

(A) Office visit—

1. For active employees enrolled in the MCHCP PPO *[300/750]* or PPO *[600/1250]* Plan, fifteen dollars (\$15) payable at the time of service;

2. For active employees enrolled in the Health Savings Account (HSA) Plan forty-five dollars (\$45) payable at the time of service; and

3. The office visit includes the evaluation and management of the patient and any associated laboratory services performed by the health center;

(B) Preventive *[care]* **services**—

1. For active employees enrolled in the MCHCP PPO *[300/750]* Plan, PPO *[600/1250]* Plan, or HSA Plan, preventive *[care is]* **services** are covered at one hundred percent (100%); and

2. Preventive *[care]* **services** shall have the same meaning as in 22 CSR 10-2.055; and

(C) Health center services are outside the MCHCP PPO *[300/750]* Plan, PPO *[600/1250]* Plan, and HSA Plan benefits and payments for health center services do not apply toward any associated deductible or out-of-pocket maximum.

AUTHORITY: section 103.059, RSMo [2000] 2016. Emergency rule filed Oct. 30, 2013, effective Jan. 1, 2014, expired June 29, 2014. Original rule filed Oct. 30, 2013, effective June 30, 2014. Amended: Filed Oct. 29, 2014, effective May 30, 2015. Amended: Filed Oct. 28, 2015, effective May 30, 2016. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Amended: Filed Oct. 31, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

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JOHN R. ASHCROFT
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SALUS POPULI SUPREMA LEX ESTO

“The welfare of the people shall be the supreme law.”



JOHN R. ASHCROFT
SECRETARY OF STATE

MISSOURI REGISTER

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August 1, 2018	September 4, 2018	September 30, 2018	October 30, 2018
August 15, 2018	September 17, 2018	September 30, 2018	October 30, 2018
September 4, 2018	October 1, 2018	October 31, 2018	November 30, 2018
September 17, 2018	October 15, 2018	October 31, 2018	November 30, 2018
October 1, 2018	November 1, 2018	November 30, 2018	December 30, 2018
October 15, 2018	November 15, 2018	November 30, 2018	December 30, 2018
November 1, 2018	December 3, 2018	December 31, 2018	January 30, 2019
November 15, 2018	December 17, 2018	December 31, 2018	January 30, 2019
December 3, 2018	January 2, 2019	January 29, 2019	February 28, 2019
December 17, 2018	January 15, 2019	January 29, 2019	February 28, 2019

Documents will be accepted for filing on all regular workdays from 8:00 a.m. until 5:00 p.m. We encourage early filings to facilitate the timely publication of the *Missouri Register*. Orders of Rulemaking appearing in the *Missouri Register* will be published in the *Code of State Regulations* and become effective as listed in the chart above. Advance notice of large volume filings will facilitate their timely publication. We reserve the right to change the schedule due to special circumstances. Please check the latest publication to verify that no changes have been made in this schedule. To review the entire year's schedule, please check out the website at www.sos.mo.gov/adrules/pubsched.

HOW TO CITE RULES AND RSMO

RULES

The rules are codified in the *Code of State Regulations* in this system–

Title		Division	Chapter	Rule
3	CSR	10-	4	.115
Department	<i>Code of State Regulations</i>	Agency Division	General area regulated	Specific area regulated

and should be cited in this manner: 3 CSR 10-4.115.

Each department of state government is assigned a title. Each agency or division in the department is assigned a division number. The agency then groups its rules into general subject matter areas called chapters and specific areas called rules. Within a rule, the first breakdown is called a section and is designated as (1). Subsection is (A) with further breakdown into paragraphs 1., subparagraphs A., parts (I), subparts (a), items I. and subitems a.

The rule is properly cited by using the full citation, for example, 3 CSR 10-4.115 NOT Rule 10-4.115.

Citations of RSMo are to the *Missouri Revised Statutes* as of the date indicated.

Code and Register on the Internet

The *Code of State Regulations* and *Missouri Register* are available on the Internet.

The *Code* address is www.sos.mo.gov/adrules/csr/csr

The *Register* address is www.sos.mo.gov/adrules/moreg/moreg

These websites contain rulemakings and regulations as they appear in the *Code* and *Registers*.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

PROPOSED AMENDMENT

22 CSR 10-3.010 Definitions. The Missouri Consolidated Health Care Plan is amending sections (19), (28), (35), (46), (47), and (70) and renumbering as necessary.

PURPOSE: This amendment revises the definitions of diabetes education, essential benefits, Health Savings Account Plan, network, and non-network; and removes the definition of terminated vested subscriber because it is duplicative of section (73); and renumbers as necessary.

(19) Diabetes **self-management** education/training. A program prescribed by a provider and taught by a Certified Diabetes Educator to educate and support members with diabetes.

(28) Essential benefits. The plan covers essential benefits as required by the Patient Protection and Affordable Care Act. Essential benefits include:

(J) Pediatric services, including oral and vision care—routine vision exam, dental care/accidental injury, *[immunizations]* **vaccinations**, preventive services, and newborn screenings.

(35) *[Health Savings Account (HSA)]* **High deductible health [P]lan.** A health plan with a higher deductible than a traditional health plan that, when combined with an **Health Savings Account (HSA)**, provides a tax-advantaged way to help save for future medical expenses.

(46) Network. The *[facilities,]* providers~~,~~ *and suppliers]* the health insurer or plan has contracted with to provide health care services **to members**.

(47) Non-network. The *[facilities,]* providers, *[and suppliers]* the health **insurer, or** plan does not contract with to provide health care services **to members. Some providers may be a part of secondary provider networks recognized by the vendor for non-network benefits.**

[(70) Terminated vested subscriber. A previous active employee eligible for a future retirement benefit through a public entity's retirement system.]

[(71)](70) Termination of coverage. The termination of medical, dental, or vision coverage initiated by the employer or required by MCHCP eligibility policies.

[(72)](71) Usual, customary, and reasonable. The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service.

[(73)](72) Vendor. The current applicable third-party administrators of MCHCP benefits or other services.

[(74)](73) Vested subscriber. An active employee eligible for coverage under the plan and eligible for future benefits through a public entity's retirement system.

[(75)](74) Waiting/probationary periods. The length of time the employer requires an employee to be employed before he or she is eligible for health insurance coverage. Public entities may set different waiting/probationary periods for different employee classifications (full-time vs. part-time).

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Amended: Filed Oct. 31, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

PROPOSED AMENDMENT

22 CSR 10-3.020 General Membership Provisions. The Missouri Consolidated Health Care Plan is amending sections (2), (3), (5), and (8).

PURPOSE: This amendment revises public entity eligibility requirements, enrollment procedures, disabled dependent documentation timeframes, and voluntary cancellation of enrollment requirements.

(2) Eligibility Requirements.

(G) Dependent Coverage. Eligible dependents include:

1. Spouse.

A. Active Employee Coverage of a Spouse.

(I) If both spouses have access to MCHCP benefits through two (2) different public entities, the employee and his/her spouse may elect to enroll in coverage separately through his/her respective employer or together through one (1) of the employers. The employee cannot have coverage through both public entities.

(II) If both spouses are employed by the same public entity with access to MCHCP benefits, the employee and spouse may elect coverage either as individuals or under the spouse (if allowed by the employer).

B. Retiree Coverage of a Spouse.

(I) A public entity retiree may enroll as a spouse under a public entity employee's coverage or elect coverage as a retiree;

2. Children.

A. Children may be covered through the end of the month in which they turn twenty-six (26) years old if they meet one (1) of the following criteria:

(I) Natural child of subscriber or spouse;

(II) Legally-adopted child of subscriber or spouse;

(III) Child legally placed for adoption of subscriber or spouse;

(IV) Stepchild of subscriber. Such child will continue to be considered a dependent after the stepchild relationship ends due to the death of the child's natural parent and subscriber's spouse;

(V) Foster child of subscriber or spouse. Such child will continue to be considered a dependent child after the foster child relationship ends by operation of law when the child ages out if the foster child relationship between the subscriber or spouse and the

child was in effect the day before the child ages out;

(VI) Grandchild for whom the subscriber or spouse has legal guardianship or legal custody;

(VII) A child for whom the subscriber or spouse is the court-ordered legal guardian under a guardianship of a minor. Such child will continue to be considered a dependent child after the guardianship ends by operation of law when the child becomes eighteen (18) years old if the guardianship of a minor relationship between the subscriber or spouse and the child was in effect the day before the child became eighteen (18) years old;

(VIII) **[Newborn] Child of a dependent [or] as long as the parent is a dependent on the child's date of birth. The dependent and his/her child must remain continuously covered on the plan from the dependent's child's date of birth for the child of the dependent to remain eligible;**

(IX) *[c]* Child of a dependent when paternity by the dependent is established after birth *[so]* as long as the parent is a dependent on *[the newborn's day of birth or]* the date the child's paternity was established *[and continues to be covered as a dependent of the subscriber]* **the dependent and his/her child must remain continuously covered on the plan from the dependent's child's date of birth for the child of the dependent to remain eligible;**

[[X]](X) Child for whom the subscriber or spouse is required to provide coverage under a Qualified Medical Child Support Order (QMCSO); or

[[X]](XI) A child under twenty-six (26) years, who is eligible for MCHCP coverage as a subscriber, may be covered as a dependent of a public entity employee.

B. A child who is twenty-six (26) years old or older and is permanently disabled in accordance with subsection (5)(F), may be covered only if such child was disabled the day before the child turned twenty-six (26) years old and has remained continuously disabled.

C. A child may only be covered by one (1) parent if his/her parents are married to each other and are both covered under an MCHCP medical plan.

D. A child may have dual coverage if the child's parents are divorced or have never married, and both have coverage under an MCHCP medical plan. MCHCP will only pay for a service once, regardless of whether the claim for the child's care is filed under multiple subscribers' coverage. If a child has coverage under two (2) subscribers, the child will have a separate deductible, copayment, and coinsurance under each subscriber. The claims administrator will process the claim and apply applicable cost-sharing using the coverage of the subscriber who files the claim first. The second claim for the same services will not be covered. If a provider files a claim simultaneously under both subscribers' coverage, the claim will be processed under the subscriber whose birthday is first in the calendar year. If both subscribers have the same birthday, the claim will be processed under the subscriber whose coverage has been in effect for the longest period of time; or

3. Changes in dependent status. If a dependent loses his/her eligibility, the subscriber must notify MCHCP within thirty-one (31) days of the loss of eligibility. Coverage will end on the last day of the month that the completed form is received by MCHCP or the last day of the month MCHCP otherwise receives credible evidence of loss of eligibility under the plan.

(3) Enrollment Procedures.

(A) Active Employee Coverage.

1. The public entity must enroll or waive coverage for a new employee by submitting a form signed by the employee and the payroll representative within thirty-one (31) days of his/her eligibility date. A new employee's coverage begins on the first day of the month after the hire date and the applicable waiting period.

2. An active employee may elect, change, or cancel coverage for the next plan year during the annual open enrollment period.

3. An active employee may *[apply for]* **elect or change** cover-

age for himself/herself and/or for his/her spouse/child(ren) if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of child(ren). A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event;

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. An employee and his/her spouse/child(ren) may enroll within sixty (60) days *[if s/he involuntarily loses]* **due to an involuntary loss** of employer-sponsored coverage under one (1) of the following circumstances:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends; or

C. If an active employee or his/her spouse/child(ren) loses MO HealthNet or Medicaid status, s/he may enroll in an MCHCP plan within sixty (60) days of the date of loss; or

D. If an active employee or active employee's spouse receives a court order stating s/he is responsible for covering a child(ren), the active employee may enroll the child(ren) in an MCHCP plan within sixty (60) days of the court order; or

E. If an active employee submits an Open Enrollment Worksheet or an Enroll/Change/Cancel/Waive form that is incomplete or contains obvious errors, MCHCP will notify the public entity's Human Resource Department of such by mail, phone, or secure message. The corrected form must be submitted to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

4. If an active employee is enrolled and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the plan offered by the public entity for the new year. If the public entity offers two (2) plan options, the employee and his/her dependents will be enrolled at the same level of coverage in the low cost plan offered by the public entity, effective the first day of the next calendar year.

(B) Retiree Coverage.

1. To enroll or continue coverage for him/herself and his/her dependents at retirement, the employee must submit one (1) of the following:

A. A completed enrollment form within thirty-one (31) days of retirement date. Coverage is effective on retirement date; or

B. A completed enrollment form within thirty-one (31) days of retirement date with proof of prior medical, dental, or vision coverage under a separate group or individual insurance policy for six (6) months immediately prior to his/her retirement if s/he chooses to enroll in an MCHCP plan at retirement and has had insurance coverage for six (6) months immediately prior to his/her retirement.

2. A retiree may later add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of child(ren). A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event;

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A retiree may enroll his/her spouse/child(ren) within sixty (60) days *[if the spouse/child(ren) involuntarily loses]* **due to an involuntary loss** of employer-sponsored coverage under one (1) of the following circumstances, and the coverage was in place for twelve (12) months

immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

3. If coverage was not maintained while on disability, the employee and his/her dependents may enroll him/herself and his/her spouse/child(ren) within thirty-one (31) days of the date the employee is eligible for retirement benefits subject to the eligibility provisions herein.

4. A retiree may change from one (1) medical plan to another during open enrollment but cannot add coverage for a spouse/child(ren). If a retiree is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

5. If a retiree submits an Open Enrollment Worksheet or an Enroll/Change/Cancel/Waive form that is incomplete or contains obvious errors, MCHCP will notify the retiree of such by mail, phone, or secure message. The retiree must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

6. If a retiree is enrolled and does not complete enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled at the same level of coverage in the plan offered by the public entity for the new year. If the public entity offers two (2) plan options, the retiree and his/her dependents will be enrolled at the same level of coverage in the low cost plan offered by the public entity, effective the first day of the next calendar year.

(C) Terminated Vested Coverage.

1. A terminated vested subscriber may later add a spouse/child(ren) to his/her coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event;

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A terminated vested subscriber may enroll his/her spouse/child(ren) within sixty (60) days *[if the spouse/child(ren) involuntarily loses]* due to an **involuntary loss** of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

2. An enrolled terminated vested subscriber may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If an enrolled terminated vested subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

3. If a terminated vested subscriber submits an Open Enrollment Worksheet or an Enroll/Change/Cancel/Waive form that is incomplete or contains obvious errors, MCHCP will notify the terminated vested subscriber of such by mail, phone, or secure message. The terminated vested subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

4. If a terminated vested subscriber is enrolled and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled at the

same level of coverage in the plan offered by the public entity for the new year. If the public entity offers two (2) plan options, the terminated vested subscriber and his/her dependents will be enrolled at the same level of coverage in the low cost plan offered by the public entity, effective the first day of the next calendar year.

(D) Long-Term Disability Coverage.

1. A long-term disability subscriber may add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of child(ren). A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event;

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A long-term disability subscriber may enroll his/her spouse/child(ren) within sixty (60) days *[if the spouse/child(ren) involuntarily loses]* due to an **involuntary loss** of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

2. An enrolled long-term disability subscriber may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If an enrolled long-term disability subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

3. If a long-term disability subscriber submits an Open Enrollment Worksheet or an Enroll/Change/Cancel/Waive form that is incomplete or contains obvious errors, MCHCP will notify the long-term disability subscriber of such by mail, phone, or secure message. The long-term disability subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

4. If a long-term disability subscriber is enrolled and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled at the same level of coverage in the plan offered by the public entity for the new year. If the public entity offers two (2) plan options, the long-term disability subscriber and his/her dependents will be enrolled at the same level of coverage in the low cost plan offered by the public entity, effective the first day of the next calendar year.

(E) Survivor Coverage.

1. A survivor must submit a form and a copy of the death certificate within thirty-one (31) days of the first day of the month after the death of the employee.

A. If the survivor does not elect coverage within thirty-one (31) days of the first day of the month after the death of the employee, s/he cannot enroll at a later date.

B. If the survivor marries, has a child, adopts a child, or a child is placed with the survivor, the spouse/child(ren) must be added within thirty-one (31) days of birth, adoption, placement, or marriage.

C. If eligible spouse/child(ren) are not enrolled when first eligible, they cannot be enrolled at a later date.

2. A survivor may later add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify

MCHCP of the life event;

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A survivor may enroll his/her spouse/child(ren) within sixty (60) days *[if the spouse/child(ren) involuntarily loses]* **due to an involuntary loss** of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

3. A survivor may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If a survivor is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

4. If a survivor submits an Open Enrollment Worksheet or an Enroll/Change/Cancel/Waive form that is incomplete or contains obvious errors, MCHCP will notify the survivor of such by mail, phone, or secure message. The survivor must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

5. If a survivor is enrolled and does not complete enrollment during the open enrollment period, the survivor and his/her dependents will be enrolled at the same level of coverage in the plan offered by the public entity for the new year. If the public entity offers two (2) plan options, the survivor and his/her dependents will be enrolled at the same level of coverage in the low cost plan offered by the public entity, effective the first day of the next calendar year.

(5) Proof of Eligibility.

(F) Disabled dependent.

1. A new employee may enroll his/her permanently disabled child or an enrolled permanently disabled dependent turning age twenty-six (26) years and may continue coverage beyond age twenty-six (26) years, provided the following documentation is submitted to the plan prior to the **end of the month of the dependent's** twenty-sixth birthday for the enrolled permanently disabled dependent or within thirty-one (31) days of enrollment of a new employee and his/her permanently disabled child:

A. Evidence from the Social Security Administration (SSA) that the permanently disabled dependent or child was entitled to and receiving disability benefits prior to turning age twenty-six (26) years; and

B. A benefit verification letter dated within the last twelve (12) months from the SSA confirming the child is still considered disabled.

2. If a disabled dependent or child over the age of twenty-six (26) years is determined to be no longer disabled by the SSA, coverage will terminate the last day of the month in which the disability ends or never take effect for new enrollment requests.

3. Once the disabled dependent's coverage is cancelled or terminated, s/he will not be able to enroll at a later date.

(8) Voluntary Cancellation of Coverage.

(D) A subscriber may only cancel dental and/or vision coverage during the year for him/herself or his/her dependents for one (1) of the following reasons:

1. Upon retirement;

2. When beginning a leave of absence;

3. No longer eligible for coverage; */or/*

4. When new coverage is taken through other employment~~/.~~; or

5. When the member enrolls in Medicaid.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Amended: Filed Oct. 31, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 3—Public Entity Membership

PROPOSED AMENDMENT

22 CSR 10-3.045 Plan Utilization Review Policy. The Missouri Consolidated Health Care Plan is amending section (1).

PURPOSE: This amendment adds preauthorization requirements for chemotherapy for cancer diagnosis, dialysis, and specialty injectibles; revises preauthorization requirements for surgery (outpatient); alphabetizes the list of medical services, and renumbers as necessary.

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program has the following components:

(A) Preauthorization of Services—The claims administrator must authorize some services in advance. Without preauthorization, any claim that requires preauthorization will be denied for payment. Members who have another primary carrier, including Medicare, are not subject to this provision except for those services that are not covered by the other primary carrier, but are otherwise subject to preauthorization under this rule. Preauthorization does not verify eligibility or payment. Preauthorizations found to have a material misrepresentation or intentional or negligent omission about the person's health condition or the cause of the condition may be rescinded.

1. The following medical services are subject to preauthorization:

A. Ambulance services for non-emergent use, whether air or ground;

B. Anesthesia and hospital charges for dental care for children younger than five (5) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization;

C. Applied behavior analysis for autism at initial service;

D. Auditory brainstem implant (ABI);

E. Bariatric surgery;

F. Cardiac rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;

G. Chelation therapy;

H. Chemotherapy for cancer diagnosis;

/G./I. Chiropractic services after twenty-six (26) visits annually;

/H./J. Cochlear implant device;

[I. Chelation therapy;]

[J./K. Dental care;

L. Dialysis;

[K./M. Durable medical equipment (DME) over one thousand five hundred dollars (\$1,500) or DME rentals over five hundred dollars (\$500) per month;

[L./N. Genetic testing or counseling;

[M./O. Hearing Aids;

[N./P. Home health care;

[O./Q. Hospice care and palliative services;

[P./R. Hospital inpatient services;

[Q./S. Imaging (diagnostic non-emergent outpatient), including magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positron emission tomography (PET), computerized tomography scan (CT), computerized tomography angiography (CTA), electron-beam computed tomography (EBCT), and nuclear cardiology;

[R./T. Maternity coverage for maternity hospital stays longer than forty-eight (48) hours for vaginal delivery or ninety-six (96) hours for cesarean delivery;

[S./U. Nutritional counseling after six (6) sessions annually;

[T./V. Orthognathic surgery;

[U./W. Orthotics over one thousand dollars (\$1,000);

[V./X. Physical, speech, and occupational therapy and rehabilitation services (outpatient) after sixty (60) combined visits per calendar year;

[W./Y. Procedures with procedure codes ending in "T" (temporary procedure codes used for data collection, experimental, investigational, or unproven procedures);

[X./Z. Prostheses over one thousand dollars (\$1,000);

[Y./AA. Pulmonary rehabilitation after thirty-six (36) visits within a twelve- (12-) week period;

[Z./BB. Skilled nursing facility;

CC. Specialty injectables;

*[AA./DD. Surgery (outpatient)—The following outpatient surgical procedures: cornea transplant, potential cosmetic surgery, sleep apnea surgery, implantable stimulators, stimulators for bone growth, spinal surgery (including, but not limited to, artificial disc replacement, fusions, nonpulsed radiofrequency denervation, vertebroplasty, kyphoplasty, spinal cord stimulator trials, spinal cord stimulator implantation, and any unlisted spinal procedure), **total hip arthroplasty, total knee arthroplasty,** and oral surgery (excisions of tumors and cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological exams); and*

[BB./EE. Transplants, including requests related to covered travel and lodging.

2. The following pharmacy services included in the prescription drug plan for non-Medicare primary members are subject to preauthorization:

A. Second-step therapy medications that skip the first-step medication trial;

B. Specialty medications;

C. Medications that may be prescribed for several conditions, including some for which treatment is not medically necessary;

D. Medication refill requests that are before the time allowed for refill;

E. Medications that exceed drug quantity and day supply limitations; and

F. Medications with costs exceeding nine thousand nine hundred ninety-nine dollars and ninety-nine cents (\$9,999.99) at retail or the mail order pharmacy and one hundred forty-nine dollars and ninety-nine cents (\$149.99) for compound medications at retail or the mail order pharmacy.

3. Preauthorization timeframes.

A. A benefit determination for non-urgent preauthorization requests will be made within fifteen (15) calendar days of the receipt of the request. The fifteen (15) days may be extended by the claims administrator for up to fifteen (15) calendar days if an extension is needed as a result of matters beyond the claims administrator's con-

trol. The claims administrator will notify the member of any necessary extension prior to the expiration of the initial fifteen- (15-) calendar-day period. If a member fails to submit necessary information to make a benefit determination, the member will be given at least ninety (90) calendar days from receipt of the extension notice to respond with additional information.

B. A benefit determination for urgent preauthorization requests will be made as soon as possible based on the clinical situation, but in no case later than twenty-four (24) hours of the receipt of the request;

*AUTHORITY: section 103.059, RSMo [2000] 2016. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Amended: Filed Oct. 31, 2018.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 3—Public Entity Membership

PROPOSED RECISSION

22 CSR 10-3.053 PPO 1000 Plan Benefit Provisions and Covered Charges. This rule established the policy of the board of trustees in regard to the PPO 1000 Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded because the PPO 1000 Plan will not be offered after December 31, 2018.

*AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the **Code of State Regulations**. Emergency rescission filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Rescinded: Filed Oct. 31, 2018.*

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars (\$500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

PROPOSED AMENDMENT

22 CSR 10-3.055 Health Savings Account Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending sections (1), (3), (6), (8), (10), and (12).

PURPOSE: This amendment revises the HSA Plan deductible, out-of-pocket maximum and clarifies influenza vaccinations, diabetes self-management education/training, family deductible, access to payment information, and maximum plan payments.

(1) Deductible—per calendar year for network: per individual, one thousand six hundred fifty dollars (\$1,650); family, three thousand three hundred dollars (\$3,300) and for non-network: per individual, *[four thousand dollars (\$4,000)]* **three thousand three hundred dollars (\$3,300)**; family, *[eight thousand dollars (\$8,000)]* **six thousand six hundred dollars (\$6,600)**.

(3) Out-of-pocket maximum.

(A) The family out-of-pocket maximum applies when two (2) or more family members are covered. The family out-of-pocket maximum must be met before the plan begins to pay one hundred percent (100%) of all covered charges for any covered family member. Out-of-pocket maximums are per calendar year, as follows:

1. Network out-of-pocket maximum for individual—*[three thousand three hundred dollars (\$3,300)]* **four thousand nine hundred fifty dollars (\$4,950)**;

2. Network out-of-pocket maximum for family—*[six thousand six hundred dollars (\$6,600)]* **nine thousand nine hundred dollars (\$9,900)**. Any individual family member need only incur a maximum of seven thousand nine hundred dollars (\$7,900) before the plan begins paying one hundred percent (100%) of covered charges for that individual;

3. Non-network out-of-pocket maximum for individual—*[five thousand dollars (\$5,000)]* **nine thousand nine hundred dollars (\$9,900)**; and

4. Non-network out-of-pocket maximum for family—*[ten thousand dollars (\$10,000)]* **nineteen thousand eight hundred dollars (\$19,800)**.

(6) Influenza *[immunizations]* **vaccinations** provided by a non-network provider will be reimbursed up to twenty-five dollars (\$25) once the member submits a receipt and a reimbursement form to the claims administrator.

(8) Four (4) diabetes **self-management** education/training visits with a certified diabetes educator when ordered by a provider and received through a network provider are covered at one hundred percent (100%) after deductible is met.

(10) Each subscriber will have access to payment information of the family unit **only when authorization is granted by the adult covered dependent(s)**.

(12) *[Usual, customary, and reasonable fee allowed]* **Maximum plan payment**—Non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed at *[the eightieth percentile of usual, customary, and reasonable fees as determined by the vendor]* **one hundred ten percent (110%) of Medicare reimbursement**. Members may be held liable for the amount of the fee above the allowed amount.

AUTHORITY: sections 103.059 and 103.080.3., RSMo 2016.

Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Amended: Filed Oct. 31, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

PROPOSED RESCISSION

22 CSR 10-3.056 PPO 600 Plan Benefit Provisions and Covered Charges. This rule established the policy of the board of trustees in regard to the PPO 600 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded because the PPO 600 Plan will not be offered after December 31, 2018.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. For intervening history, please consult the *Code of State Regulations*. Emergency rescission filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Rescinded: Filed Oct. 31, 2018.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

PROPOSED AMENDMENT

22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges. The Missouri Consolidated Health Care Plan is amending

sections (1) and (3).

PURPOSE: This amendment revises the names of the medical plans and clarifies the following benefits: dental care, diabetes education, dialysis, genetic counseling, infusions, injections, nutrition counseling, and preventive services; alphabetizes the list of medical benefits; and renumbers as necessary.

(1) Benefit Provisions Applicable to the PPO [600] 750 Plan, PPO [1000] 1250 Plan, and Health Savings Account (HSA) Plan. Subject to the plan provisions, limitations, and enrollment of the employee, the benefits are payable for covered charges incurred by a member while covered under the plans, provided the deductible requirement, if any, is met.

(3) Covered Charges Applicable to the PPO [600] 750 Plan, PPO [1000] 1250 Plan, and HSA Plan.

(E) Plan benefits for the PPO [600] 750 Plan, PPO [1000] 1250 Plan, and HSA Plan are as follows:

1. Allergy Testing and Immunotherapy. Allergy testing and allergy immunotherapy are considered medically necessary for members with clinically significant allergic symptoms. The following tests and treatments are covered:

A. Epicutaneous (scratch, prick, or puncture) when Immunoglobulin E- (IgE-) mediated reactions occur to any of the following:

- (I) Foods;
- (II) Hymenoptera venom (stinging insects);
- (III) Inhalants; or
- (IV) Specific drugs (penicillins and macromolecular agents);

B. Intradermal (Intracutaneous) when IgE-mediated reactions occur to any of the following:

- (I) Foods;
- (II) Hymenoptera venom (stinging insects);
- (III) Inhalants; or
- (IV) Specific drugs (penicillins and macromolecular agents);

C. Skin or Serial Endpoint Titration (SET), also known as intradermal dilutional testing (IDT), for determining the starting dose for immunotherapy for members highly allergic to any of the following:

- (I) Hymenoptera venom (stinging insects); or
- (II) Inhalants;

D. Skin Patch Testing: for diagnosing contact allergic dermatitis;

E. Photo Patch Testing: for diagnosing photo-allergy (such as photo-allergic contact dermatitis);

F. Photo Tests: for evaluating photo-sensitivity disorders;

G. Bronchial Challenge Test: for testing with methacholine, histamine, or antigens in defining asthma or airway hyperactivity when either of the following conditions is met:

- (I) Bronchial challenge test is being used to identify new allergens for which skin or blood testing has not been validated; or
- (II) Skin testing is unreliable;

H. Exercise Challenge Testing for exercise-induced bronchospasm;

I. Ingestion (Oral) Challenge Test for any of the following:

- (I) Food or other substances; or
- (II) Drugs when all of the following are met:
 - (a) History of allergy to a particular drug;
 - (b) There is no effective alternative drug; and
 - (c) Treatment with that drug class is essential;

J. In Vitro IgE Antibody Tests (RAST, MAST, FAST, ELISA, ImmunoCAP) are covered for any of the following:

- (I) Allergic broncho-pulmonary aspergillosis (ABPA) and certain parasitic diseases;
- (II) Food allergy;
- (III) Hymenoptera venom allergy (stinging insects);

(IV) Inhalant allergy; or

(V) Specific drugs;

K. Total Serum IgE for diagnostic evaluation in members with known or suspected ABPA and/or hyper IgE syndrome;

L. Lymphocyte transformation tests such as lymphocyte mitogen response test, PHE stimulation test, or lymphocyte antigen response assay are covered for evaluation of persons with any of the following suspected conditions:

(I) Sensitivity to beryllium;

(II) Congenital or acquired immunodeficiency diseases affecting cell-mediated immunity, such as severe combined immunodeficiency, common variable immunodeficiency, X-linked immunodeficiency with hyper IgM, Nijmegen breakage syndrome, reticular dysgenesis, DiGeorge syndrome, Nezelof syndrome, Wiscott-Aldrich syndrome, ataxia telangiectasia, and chronic mucocutaneous candidiasis;

(III) Thymoma; and

(IV) To predict allograft compatibility in the transplant setting;

M. Allergy retesting: routine allergy retesting is not considered medically necessary;

N. Allergy immunotherapy is covered for the treatment of any of the following IgE-mediated allergies:

- (I) Allergic (extrinsic) asthma;
- (II) Dust mite atopic dermatitis;
- (III) Hymenoptera (bees, hornets, wasps, fire ants) sensitive individuals;
- (IV) Mold-induced allergic rhinitis;
- (V) Perennial rhinitis;
- (VI) Seasonal allergic rhinitis or conjunctivitis when one

(1) of the following conditions are met:

(a) Member has symptoms of allergic rhinitis or asthma after natural exposure to the allergen;

(b) Member has a life-threatening allergy to insect stings; or

(c) Member has skin test or serologic evidence of IgE-mediated antibody to a potent extract of the allergen; and

(VII) Avoidance or pharmacologic therapy cannot control allergic symptoms or member has unacceptable side effects with pharmacologic therapy;

O. Other treatments: the following other treatments are covered:

(I) Rapid, rush, cluster, or acute desensitization for members with any of the following conditions:

(a) IgE antibodies to a particular drug that cannot be treated effectively with alternative medications;

(b) Insect sting (e.g., wasps, hornets, bees, fire ants) hypersensitivity (hymenoptera); or

(c) Members with moderate to severe allergic rhinitis who need treatment during or immediately before the season of the affecting allergy;

(II) Rapid desensitization is considered experimental and investigational for other indications;

P. Epinephrine kits, to prevent anaphylactic shock for members who have had life-threatening reactions to insect stings, foods, drugs, or other allergens; have severe asthma or if needed during immunotherapy;

2. Ambulance service. The following ambulance transport services are covered:

A. By ground to the nearest appropriate facility when other means of transportation would be contraindicated;

B. By air to the nearest appropriate facility when the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate or contraindicated;

3. Applied Behavior Analysis (ABA) for Autism;

4. Bariatric surgery. Bariatric surgery is covered when all of the following requirements have been met:

A. The surgery is performed at a facility accredited by the

Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) for the billed procedure;

B. The following open or laparoscopic bariatric surgery procedures are covered:

(I) Roux-en-Y gastric bypass;

(II) Sleeve gastrectomy;

(III) Biliopancreatic diversion with duodenal switch for individuals with a body mass index (BMI) greater than fifty (50);

(IV) Adjustable silicone gastric banding and adjustments of a silicone gastric banding to control the rate of weight loss and/or treat symptoms secondary to gastric restriction following an adjustable silicone gastric banding procedure;

(V) Surgical reversal of bariatric surgery when complications of the original surgery (e.g., stricture, pouch dilatation, erosion, or band slippage) cause abdominal pain, inability to eat or drink, or cause vomiting of prescribed meals;

(VI) Revision of a previous bariatric surgical procedure or conversion to another procedure due to inadequate weight loss when one (1) of the following specific criteria has been met:

(a) There is evidence of full compliance with the previously prescribed post-operative dietary and exercise program; or

(b) There is documented clinical testing demonstrating technical failure of the original bariatric surgical procedure which caused the individual to fail achieving adequate weight loss of at least fifty percent (50%) of excess body weight or failure to achieve body weight to within thirty percent (30%) of ideal body weight at least two (2) years following the original surgery;

C. All of the following criteria have been met:

(I) The member is eighteen (18) years or older or has reached full skeletal growth, and has evidence of one (1) of the following:

(a) BMI greater than forty (40); or

(b) BMI between thirty-five (35) and thirty-nine and nine tenths (39.9) and one (1) or more of the following:

I. Type II diabetes;

II. Cardiovascular disease such as stroke, myocardial infarction, stable or unstable angina pectoris, hypertension, or coronary artery bypass; or

III. Life-threatening cardiopulmonary problems such as severe sleep apnea, Pickwickian syndrome, or obesity-related cardiomyopathy; and

(II) Demonstration that dietary attempts at weight control have been ineffective through completion of a structured diet program. Commercial weight loss programs are acceptable if completed under the direction of a provider or registered dietitian and documentation of participation is available for review. One (1) structured diet program for six (6) consecutive months or two (2) structured diet programs for three (3) consecutive months each within a two- (2-) year period prior to the request for the surgical treatment of morbid obesity are sufficient. Provider-supervised programs consisting exclusively of pharmacological management are not sufficient; and

(III) A thorough multidisciplinary evaluation within the previous twelve (12) months, which include all of the following:

(a) An evaluation by a bariatric surgeon recommending surgical treatment, including a description of the proposed procedure and all of the associated current procedural terminology codes;

(b) A separate medical evaluation from a provider other than the surgeon recommending surgery that includes a medical clearance for bariatric surgery;

(c) Completion of a psychological examination from a mental health provider evaluating the member's readiness and fitness for surgery and the necessary post-operative lifestyle changes. After the evaluation, the mental health provider must provide clearance for bariatric surgery; and

(d) A nutritional evaluation by a provider or registered dietitian;

5. Blood storage. Storage of whole blood, blood plasma, and blood products is covered in conjunction with medical treatment that requires immediate blood transfusion support;

/5./6. Bone Growth Stimulators. Implantable bone growth stimulators are covered as an outpatient surgery benefit. The following nonimplantable bone growth stimulators are covered as a durable medical equipment benefit:

A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)) to accelerate healing of fresh fractures, fusions, or delayed unions at either of the following high-risk sites:

(I) Fresh fractures, fusions, or delayed unions of the shaft (diaphysis) of the tibia that are open or segmental; or

(II) Fresh fractures, fusions, or delayed unions of the scaphoid (carpal navicular);

B. Ultrasonic osteogenesis stimulator for non-unions, failed arthrodesis, and congenital pseudarthrosis (pseudoarthrosis) of the appendicular skeleton if there has been no progression of healing for three (3) or more months despite appropriate fracture care; or

C. Direct current electrical bone-growth stimulator is covered for the following indications:

(I) Delayed unions of fractures or failed arthrodesis at high-risk sites (i.e., open or segmental tibial fractures, carpal navicular fractures);

(II) Non-unions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three (3) or more months despite appropriate fracture care; or

(III) Members who are at high risk for spinal fusion failure when any of the following criteria is met:

(a) A multiple-level fusion entailing three (3) or more vertebrae (e.g., L3 to L5, L4 to S1, etc.);

(b) Grade II or worse spondylolisthesis; or

(c) One (1) or more failed fusions;

/6./7. Contraception and Sterilization. All Food and Drug Administration- (FDA-) approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity;

/7. Blood storage. Storage of whole blood, blood plasma, and blood products is covered in conjunction with medical treatment that requires immediate blood transfusion support;]

8. Cardiac rehabilitation. An electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) is covered for specific criteria when it is individually prescribed by a provider and a formal exercise stress test is completed following the event and prior to the initiation of the program. Cardiac rehabilitation is covered for members who meet one (1) of the following criteria:

A. Acute myocardial infarction (MI) (heart attack in the last twelve (12) months);

B. Coronary artery bypass grafting (CABG);

C. Stable angina pectoris;

D. Percutaneous coronary vessel remodeling;

E. Valve replacement or repair;

F. Heart transplant;

G. Coronary artery disease (CAD) associated with chronic stable angina that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities; or

H. Heart failure that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities;

9. Chelation therapy. The administration of FDA-approved chelating agents is covered for any of the following conditions:

A. Genetic or hereditary hemochromatosis;

B. Lead overload in cases of acute or long-term lead exposure;

C. Secondary hemochromatosis due to chronic iron overload due to transfusion-dependent anemias (e.g., Thalassemias, Cooley's anemia, sickle cell anemia, sideroblastic anemia);

D. Copper overload in patients with Wilson's disease;

E. Arsenic, mercury, iron, copper, or gold poisoning when

long-term exposure to and toxicity has been confirmed through lab results or clinical findings consistent with metal toxicity;

- F. Aluminum overload in chronic hemodialysis patients;
- G. Emergency treatment of hypercalcemia;
- H. Prophylaxis against doxorubicin-induced cardiomyopathy;
- I. Internal plutonium, americium, or curium contamination;

or

- J. Cystinuria;

10. Chiropractic services. Chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) are covered when all of the following conditions are met:

A. A neuromusculoskeletal condition is diagnosed that may be relieved by standard chiropractic treatment in order to restore optimal function;

B. Chiropractic care is being performed by a licensed doctor of chiropractic who is practicing within the scope of his/her license as defined by state law;

C. The individual is involved in a treatment program that clearly documents all of the following:

(I) A prescribed treatment program that is expected to result in significant therapeutic improvement over a clearly defined period of time;

(II) The symptoms being treated;

(III) Diagnostic procedures and results;

(IV) Frequency, duration, and results of planned treatment modalities;

(V) Anticipated length of treatment plan with identification of quantifiable, attainable short-term and long-term goals; and

(VI) Demonstrated progress toward significant functional gains and/or improved activity tolerances;

D. Following previous successful treatment with chiropractic care, acute exacerbation or re-injury are covered when all of the following criteria are met:

(I) The member reached maximal therapeutic benefit with prior chiropractic treatment;

(II) The member was compliant with a self-directed home-care program;

(III) Significant therapeutic improvement is expected with continued treatment; and

(IV) The anticipated length of treatment is expected to be short-term (e.g., no more than six (6) visits within a three- (3-) week period);

11. Clinical trials. Routine member care costs incurred as the result of a Phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition are covered when—

A. The study or investigation is conducted under an investigational new drug application reviewed by the FDA; or

B. Is a drug trial that is exempt from having such an investigational new drug application. Life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted; and

C. Routine member care costs include all items and services consistent with the coverage provided in plan benefits that would otherwise be covered for a member not enrolled in a clinical trial. Routine patient care costs do not include the investigational item, device, or service itself; items and services that are provided solely to satisfy data collection and analysis needs and are not used in the direct clinical management of the member; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

D. The member must be eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

E. The clinical trial must be approved or funded by one (1) of the following:

(I) National Institutes of Health (NIH);

(II) Centers for Disease Control and Prevention (CDC);

(III) Agency for Health Care Research and Quality;

(IV) Centers for Medicare & Medicaid Services (CMS);

(V) A cooperative group or center of any of the previously named agencies or the Department of Defense or the Department of Veterans Affairs;

(VI) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

(VII) A study or investigation that is conducted by the Department of Veterans Affairs, the Department of Defense, or the Department of Energy and has been reviewed and approved to be comparable to the system of peer review of studies and investigations used by the NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

12. Cochlear implant device. Uniaural (monaural) or binaural (bilateral) cochlear implantation and necessary replacement batteries are covered for a member with bilateral, pre- or post-linguistic, sensorineural, moderate-to-profound hearing impairment when there is reasonable expectation that a significant benefit will be achieved from the device and when the following age-specific criteria are met:

A. Auditory brainstem implant. Auditory brainstem implant (ABI) covered for the diagnosis of neurofibromatosis type II, von Recklinghausen's disease, or when a member is undergoing bilateral removal of tumors of the auditory nerves, and it is anticipated that the member will become completely deaf as a result of the surgery, or the member had bilateral auditory nerve tumors removed and is now bilaterally deaf;

(I) For an adult (age eighteen (18) years or older) with BOTH of the following:

(a) Bilateral, severe to profound sensorineural hearing loss determined by a pure-tone average of seventy (70) decibels (dB) hearing loss or greater at five hundred (500) hertz (Hz), one thousand (1000) Hz, and two thousand (2000) Hz; and

(b) Member has limited benefit from appropriately fitted binaural hearing aids. Limited benefit from amplification is defined by test scores of forty percent (40%) correct or less in best-aided listening condition on open-set sentence cognition (e.g., Central Institute for the Deaf (CID) sentences, Hearing in Noise Test (HINT) sentences, and Consonant-Nucleus-Consonant (CNC) test);

(II) For a child age twelve (12) months to seventeen (17) years, eleven (11) months with both of the following:

(a) Profound, bilateral sensorineural hearing loss with thresholds of ninety (90) dB or greater at one thousand (1000) Hz; and

(b) Limited or no benefit from a three- (3-) month trial of appropriately fitted binaural hearing aids;

(III) For children four (4) years of age or younger, with one (1) of the following:

(a) Failure to reach developmentally appropriate auditory milestones measured using the Infant-Toddler Meaningful Auditory Integration Scale, the Meaningful Auditory Integration Scale, or the Early Speech Perception test; or

(b) Less than twenty percent (20%) correct on open-set word recognition test Multisyllabic Lexical Neighborhood Test (MLNT) in conjunction with appropriate amplification and participation in intensive aural habilitation over a three- (3-) to six- (6-) month period;

(IV) For children older than four (4) years of age with one (1) of the following:

(a) Less than twelve percent (12%) correct on the Phonetically Balanced-Kindergarten Test; or

(b) Less than thirty percent (30%) correct on the HINT for children, the open-set Multisyllabic Lexical Neighborhood Test (MLNT) or Lexical Neighborhood Test (LNT), depending on the child's cognitive ability and linguistic skills; and

(V) A three- (3-) to six- (6-) month hearing aid trial has been undertaken by a child without previous experience with hearing aids;

B. Radiologic evidence of cochlear ossification;

C. The following additional medical necessity criteria must be met for uniaural (monaural) or binaural (bilateral) cochlear implantation in adults and children:

(I) Member must be enrolled in an educational program that supports listening and speaking with aided hearing;

(II) Member must have had an assessment by an audiologist and from an otolaryngologist experienced in this procedure indicating the likelihood of success with this device;

(III) Member must have no medical contraindications to cochlear implantation (e.g., cochlear aplasia, active middle ear infection); and

(IV) Member must have arrangements for appropriate follow-up care, including the speech therapy required to take full advantage of this device;

D. A second cochlear implant is covered in the contralateral (opposite) ear as medically necessary in an individual with an existing unilateral cochlear implant when the hearing aid in the contralateral ear produces limited or no benefit;

E. The replacement of an existing cochlear implant is covered when either of the following criteria is met:

(I) Currently used component is no longer functional and cannot be repaired; or

(II) Currently used component renders the implant recipient unable to adequately and/or safely perform his/her age-appropriate activities of daily living; and

F. Post-cochlear or ABI rehabilitation program (aural rehabilitation) is covered to achieve benefit from a covered device;

13. Dental care.

A. Dental care is covered for *[treatment of trauma to the mouth, jaw, teeth, or contiguous sites, as a result of accidental injury.] the following:*

(I) Treatment to reduce trauma and restorative services limited to dental implants only when the result of accidental injury to sound natural teeth and tissue that are viable, functional, and free of disease. **Treatment must be initiated within sixty (60) days of accident; and**

(II) Restorative services limited to dental implants when needed as a result of cancerous or non-cancerous tumors and cysts, cancer, and post-surgical sequelae.

B. The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization when provided in a network or non-network hospital or surgical center;

14. Diabetes **self-management training**/E/education when prescribed by a provider and taught by a Certified Diabetes Educator through a medical network provider;

15. Dialysis is covered when received through a network provider;

[15./16. Durable medical equipment (DME) is covered when ordered by a provider to treat an injury or illness. DME includes, but is not limited to, the following:

A. Insulin pumps;

B. Oxygen;

C. Augmentative communication devices;

D. Manual and powered mobility devices;

E. Disposable supplies that do not withstand prolonged use and are periodically replaced, including, but not limited to, the following:

(I) Colostomy and ureterostomy bags;

(II) Prescription compression stockings limited to two (2) pairs or four (4) individual stockings per plan year;

F. Blood pressure cuffs/monitors with a diagnosis of diabetes;

G. Repair and replacement of DME is covered when any of the following criteria are met:

(I) Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

(II) Routine wear and tear of the equipment renders it non-functional and the member still requires the equipment; or

(III) The provider has documented that the condition of the member changes or if growth-related;

[16./17. Emergency room services. Coverage is for emergency medical conditions. If a member is admitted to the hospital, s/he may be required to transfer to network facility for maximum benefit. Hospital and ancillary charges are paid as a network benefit;

[17./18. Eye glasses and contact lenses. Coverage limited to charges incurred in connection with the fitting of eye glasses or contact lenses for initial placement within one (1) year following cataract surgery;

[18./19. Foot care (trimming of nails, corns, or calluses). Foot care services are covered when administered by a provider and—

A. When associated with systemic conditions that are significant enough to result in severe circulatory insufficiency or areas of desensitization in the lower extremities including, but not limited to, any of the following:

(I) Diabetes mellitus;

(II) Peripheral vascular disease; or

(III) Peripheral neuropathy.

(IV) Evaluation/debridement of mycotic nails, in the absence of a systemic condition, when both of the following conditions are met:

(a) Pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate; and

(b) If the member is ambulatory, pain markedly limits ambulation;

[19./20. Genetic counseling. Pre-test and post-test genetic counseling with a provider or a licensed or certified genetic counselor are covered when a member is recommended for covered heritable genetic testing.

A. Genetic counseling in connection with pregnancy management is covered only for evaluation of any of the following:

(I) Couples who are closely related genetically (e.g., consanguinity, incest);

(II) Familial cancer disorders;

(III) Individuals recognized to be at increased risk for genetic disorders;

(IV) Infertility cases where either parent is known to have a chromosomal abnormality;

(V) Primary amenorrhea, *[azospermia]* **azoospermia**, abnormal sexual development, or failure in developing secondary sexual characteristics;

(VI) Mother is a known, or presumed carrier of an X linked recessive disorder;

(VII) One (1) or both parents are known carriers of an autosomal recessive disorder;

(VIII) Parents of a child born with a genetic disorder, birth defect, inborn error of metabolism, or chromosome abnormality;

(IX) Parents of a child with intellectual developmental disorders, autism, developmental delays, or learning disabilities;

(X) Pregnant women who, based on prenatal ultrasound tests or an abnormal multiple marker screening test, maternal serum alpha-fetoprotein (AFP) test, test for sickle cell anemia, or tests for other genetic abnormalities have been told their pregnancy may be at increased risk for complications or birth defects;

(XI) Pregnant women age thirty-five (35) years or older at delivery;

(XII) Pregnant women, or women planning pregnancy, exposed to potentially teratogenic, mutagenic, or carcinogenic agents such as chemicals, drugs, infections, or radiation;

(XIII) Previous unexplained stillbirth or repeated (three (3) or more; two (2) or more among infertile couples) first-trimester miscarriages, where there is suspicion of parental or fetal chromosome abnormalities; or

(XIV) When contemplating pregnancy, either parent affected with an autosomal dominant disorder;

[20./21. Genetic testing.

A. Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following criteria are met:

(I) The member displays clinical features or is at direct risk of inheriting the mutation in question (pre-symptomatic);

(II) The result of the test will directly impact the treatment being delivered to the member;

(III) The testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and

(IV) After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain;

B. Genetic testing for the breast cancer susceptibility gene (BRCA) when family history is present;

[21.]/22. Hair analysis. Chemical hair analysis is covered for the diagnosis of suspected chronic arsenic poisoning. Other purposes are considered experimental and investigational;

[22.]/23. Hair prostheses. Prostheses and expenses for scalp hair prostheses worn for hair loss are covered for alopecia areata or alopecia totalis for children eighteen (18) years of age or younger. The annual maximum is two hundred dollars (\$200), and the lifetime maximum is three thousand two hundred dollars (\$3,200);

[23.]/24. Hearing aids (per ear). Hearing aids covered for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss.

A. Prior to receiving a hearing aid members must receive—

(I) A medical exam by a physician or other qualified provider to identify any medically treatable conditions that may affect hearing; and

(II) A comprehensive hearing test to assess the need for hearing aids conducted by a certified audiologist, hearing instrument specialist, or other provider licensed or certified to administer this test.

B. Covered once every two (2) years. If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

(I) Conventional: one thousand dollars (\$1,000).

(II) Programmable: two thousand dollars (\$2,000).

(III) Digital: two thousand five hundred dollars (\$2,500).

(IV) Bone Anchoring Hearing Aid (BAHA): three thousand five hundred dollars (\$3,500);

[24.]/25. Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by provider;

[25.]/26. Home health care. Skilled home health nursing care is covered for members who are homebound because of injury or illness (i.e., the member leaves home only with considerable and taxing effort, and absences from home are infrequent or of short duration, or to receive medical care). Services must be performed by a registered nurse or licensed practical nurse, licensed therapist, or a registered dietitian. Covered services include:

A. Home visits instead of visits to the provider's office that do not exceed the usual and customary charge to perform the same service in a provider's office;

B. Intermittent nurse services. Benefits are paid for only one (1) nurse at any one (1) time, not to exceed four (4) hours per twenty-four- (24-) hour period;

C. Nutrition counseling provided by or under the supervision of a registered dietitian;

D. Physical, occupational, respiratory, and speech therapy provided by or under the supervision of a licensed therapist;

E. Medical supplies, drugs or medication prescribed by provider, and laboratory services to the extent that the plan would have covered them under this plan if the covered person had been in a hospital;

F. A home health care visit is defined as—

(I) A visit by a nurse providing intermittent nurse services (each visit includes up to a four- (4-) hour consecutive visit in a twenty-four- (24-) hour period if clinical eligibility for coverage is met) or a single visit by a therapist or a registered dietitian; and

G. Benefits cannot be provided for any of the following:

(I) Homemaker or housekeeping services;

(II) Supportive environment materials such as handrails, ramps, air conditioners, and telephones;

(III) Services performed by family members or volunteer workers;

(IV) "Meals on Wheels" or similar food service;

(V) Separate charges for records, reports, or transportation;

(VI) Expenses for the normal necessities of living such as food, clothing, and household supplies; and

(VII) Legal and financial counseling services, unless otherwise covered under this plan;

[26.]/27. Hospice care and palliative services (inpatient or outpatient). Includes bereavement and respite care. Hospice care services, including pre-hospice evaluation or consultation, are covered when the individual is terminally ill and expected to live six (6) months or less, potentially curative treatment for the terminal illness is not part of the prescribed plan of care, the individual or appointed designee has formally consented to hospice care (i.e., care directed mostly toward palliative care and symptom management), and the hospice services are provided by a certified/accredited hospice agency with care available twenty-four (24) hours per day, seven (7) days per week.

A. When the above criteria are met, the following hospice care services are covered:

(I) Assessment of the medical and social needs of the terminally ill person, and a description of the care to meet those needs;

(II) Inpatient care in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy, and part-time home health care services;

(III) Outpatient care for other services as related to the terminal illness, which include services of a physician, physical or occupational therapy, and nutrition counseling provided by or under the supervision of a registered dietitian; and

(IV) Bereavement counseling benefits which are received by a member's close relative when directly connected to the member's death and bundled with other hospice charges. The services must be furnished within twelve (12) months of death;

[27.]/28. Hospital (includes inpatient, outpatient, and surgical centers).

A. The following benefits are covered:

(I) Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a covered expense only when clinical eligibility for coverage is met. If the hospital has no semi-private rooms, the plan will allow the private room rate subject to usual, customary, and reasonable charges or the network rate, whichever is applicable;

(II) Intensive care unit room and board;

(III) Surgery, therapies, and ancillary services including, but not limited to:

(a) Cornea transplant;

(b) Coverage for breast reconstruction surgery or prostheses following mastectomy and lumpectomy is available to both females and males. A diagnosis of breast cancer is not required for breast reconstruction services to be covered, and the timing of reconstructive services is not a factor in coverage;

(c) Sterilization for the purpose of birth control is covered;

(d) Cosmetic/reconstructive surgery is covered to repair a functional disorder caused by disease or injury;

(e) Cosmetic/reconstructive surgery is covered to repair a congenital defect or abnormality for a member younger than nineteen (19) years; and

(f) Blood, blood plasma, and plasma expanders are covered, when not available without charge;

(IV) Inpatient mental health services are covered when

authorized by a physician for treatment of a mental health disorder. Inpatient mental health services are covered, subject to all of the following:

(a) Member must be ill in more than one (1) area of daily living to such an extent that s/he is rendered dysfunctional and requires the intensity of an inpatient setting for treatment. Without such inpatient treatment, the member's condition would deteriorate;

(b) The member's mental health disorder must be treatable in an inpatient facility;

(c) The member's mental health disorder must meet diagnostic criteria as described in the most recent edition of the *American Psychiatric Association Diagnostic and Statistical Manual (DSM)*. If outside of the United States, the member's mental health disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region;

(d) The attending provider must be a psychiatrist. If the admitting provider is not a psychiatrist, a psychiatrist must be attending to the member within twenty-four (24) hours of admittance. Such psychiatrist must be United States board-eligible or board-certified. If outside of the United States, inpatient services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending provider must meet the requirements, if any, set out by the foreign government or regionally-recognized licensing body for treatment of mental health disorders;

(e) Day treatment (partial hospitalization) for mental health services means a day treatment program that offers intensive, multidisciplinary services provided on less than a full-time basis. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and pre-occupational modalities. Such programs must be a less-restrictive alternative to inpatient treatment; and

(f) Mental health services received in a residential treatment facility that is licensed by the state in which it operates and provides treatment for mental health disorders is covered. This does not include services provided at a group home. If outside of the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and

(V) Outpatient mental health services are covered if the member is at a therapeutic medical or mental health facility and treatment includes measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident. Treatment must be provided by one (1) of the following:

(a) A United States board-eligible or board-certified psychiatrist licensed in the state where the treatment is provided;

(b) A therapist with a doctorate or master's degree that denotes a specialty in psychiatry (Psy.D.);

(c) A state-licensed psychologist;

(d) A state-licensed or certified social worker practicing within the scope of his or her license or certification; or

(e) Licensed professional counselor;

29. Infusions are covered when received through a network provider. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered are not a medical plan benefit but are covered as part of the pharmacy benefit;

[28./30. Injections [and infusions. Injections and infusions are covered]. See preventive services for coverage of [immunizations/ vaccinations. See contraception and sterilization for coverage of birth control injections. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered[, including injectables,] are not a medical plan benefit but are covered as part of the pharmacy benefit.

A. B12 injections are covered for the following conditions:

(I) Pernicious anemia;

(II) Crohn's disease;

(III) Ulcerative colitis;

(IV) Inflammatory bowel disease;

(V) Intestinal malabsorption;

(VI) Fish tapeworm anemia;

(VII) Vitamin B12 deficiency;

(VIII) Other vitamin B12 deficiency anemia;

(IX) Macrocytic anemia;

(X) Other specified megaloblastic anemias;

(XI) Megaloblastic anemia;

(XII) Malnutrition of alcoholism;

(XIII) Thrombocytopenia, unspecified;

(XIV) Dementia in conditions classified elsewhere;

(XV) Polyneuropathy in diseases classified elsewhere;

(XVI) Alcoholic polyneuropathy;

(XVII) Regional enteritis of small intestine;

(XVIII) Postgastric surgery syndromes;

(XIX) Other prophylactic chemo-therapy;

(XX) Intestinal bypass or anastomosis status;

(XXI) Acquired absence of stomach;

(XXII) Pancreatic insufficiency; and

(XXIII) Ideopathic progressive polyneuropathy;

[29./31. Lab, X-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition. Professional charges for automated lab services performed by an out-of-network provider are not covered;

[30./32. Maternity coverage. Prenatal and postnatal care is covered. Routine prenatal office visits and screenings recommended by the Health Resources and Services Administration are covered at one hundred percent (100%). Other care is subject to the deductible and coinsurance. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after vaginal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post discharge care that shall consist of a two- (2-) visit minimum, at least one (1) in the home;

[31./33. Nutritional counseling. Individualized nutritional evaluation and counseling for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program is covered when ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian);

[32./34. Nutrition therapy.

A. Nutrition therapy is covered only when the following criteria are met:

(I) Nutrition therapy is the sole source of nutrients or a significant percentage of the daily caloric intake;

(II) Nutrition therapy is used in the treatment of, or in association with, a demonstrable disease, condition, or disorder;

(III) Nutrition therapy is necessary to sustain life or health;

(IV) Nutrition therapy is prescribed by a provider; and

(V) Nutrition therapy is managed, monitored, and evaluated on an on-going basis, by a provider.

B. Only the following types of nutrition therapy are covered:

(I) Enteral Nutrition (EN). EN is the provision of nutritional requirements via the gastrointestinal tract. EN can be taken orally or through a tube into the stomach or small intestine;

(II) Parenteral Nutrition Therapy (PN) and Total Parenteral Nutrition (TPN). PN is liquid nutrition administered through a vein to provide part of daily nutritional requirements. TPN is a type of PN that provides all daily nutrient needs. PN or TPN are covered when the member's nutritional status cannot be adequately maintained on oral or enteral feedings;

(III) Intradialytic Parenteral Nutrition (IDPN). IDPN is a type of PN that is administered to members on chronic hemodialysis during dialysis sessions to provide most nutrient needs. IDPN is covered when the member is on chronic hemodialysis and nutritional status cannot be adequately maintained on oral or enteral feedings;

[33./35. Office visit. Member encounter with a provider for health care, mental health, or substance use disorder in an office,

clinic, or ambulatory care facility is covered based on the service, procedure, or related treatment plan;

[34.]36. Oral surgery is covered for injury, tumors, or cysts. Oral surgery includes, but is not limited to, reduction of fractures and dislocation of the jaws; external incision and drainage of cellulites; incision of accessory sinuses, salivary glands, or ducts; excision of exostosis of jaws and hard palate; and frenectomy. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. Extractions of bony or partial bony impactions are excluded;

[35.]37. Orthognathic or Jaw Surgery. Orthognathic or jaw surgery is covered when one (1) of the following conditions is documented and diagnosed:

A. Acute traumatic injury, and post-surgical sequela;

B. Cancerous or non-cancerous tumors and cysts, cancer, and post-surgical sequela;

C. Cleft lip/palate (for cleft lip/palate related jaw surgery); or

D. Physical or physiological abnormality when one (1) of the following criteria is met:

(I) Anteroposterior Discrepancies—

(a) Maxillary/Mandibular incisor relationship: over jet of 5mm or more, or a 0 to a negative value (norm 2mm);

(b) Maxillary/Mandibular anteroposterior molar relationship discrepancy of 4mm or more (norm 0 to 1mm); or

(c) These values represent two (2) or more standard deviation from published norms;

(II) Vertical Discrepancies—

(a) Presence of a vertical facial skeletal deformity which is two (2) or more standard deviations from published norms for accepted skeletal landmarks;

(b) Open bite with no vertical overlap of anterior teeth or unilateral or bilateral posterior open bite greater than 2mm;

(c) Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch; or

(d) Supraeruption of a dentoalveolar segment due to lack of occlusion;

(III) Transverse Discrepancies—

(a) Presence of a transverse skeletal discrepancy which is two (2) or more standard deviations from published norms; or

(b) Total bilateral maxillary palatal cusp to mandibular-fossa discrepancy of 4mm or greater, or a unilateral discrepancy of 3mm or greater, given normal axial inclination of the posterior teeth; or

(IV) Asymmetries—

(a) Anteroposterior, transverse, or lateral asymmetries greater than 3mm with concomitant occlusal asymmetry;

(V) Masticatory (chewing) and swallowing dysfunction due to malocclusion (e.g., inability to incise or chew solid foods, choking on incompletely masticated solid foods, damage to soft tissue during mastication, malnutrition);

(VI) Speech impairment; or

(VII) Obstructive sleep apnea or airway dysfunction;

[36.]38. Orthotics.

A. Ankle-Foot Orthosis (AFO) and Knee-Ankle-Foot Orthosis (KAFO).

(I) Basic coverage criteria for AFO and KAFO used during ambulation are as follows:

(a) AFO is covered when used in ambulation for members with weakness or deformity of the foot and ankle, which require stabilization for medical reasons, and have the potential to benefit functionally;

(b) KAFO is covered when used in ambulation for members when the following criteria are met:

I. Member is covered for AFO; and

II. Additional knee stability is required; and

(c) AFO and KAFO that are molded-to-patient-model, or custom-fabricated, are covered when used in ambulation, only when the basic coverage criteria and one (1) of the following criteria are met:

I. The member could not be fitted with a prefabricated AFO;

II. AFO or KAFO is expected to be permanent or for more than six (6) months duration;

III. Knee, ankle, or foot must be controlled in more than one (1) plane;

IV. There is documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or

V. The member has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

(II) AFO and KAFO Not Used During Ambulation.

(a) AFO and KAFO not used in ambulation are covered if the following criteria are met:

I. Passive range of motion test was measured with goniometer and documented in the medical record;

II. Documentation of an appropriate stretching program administered under the care of provider or caregiver;

III. Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least ten degrees (10°) (i.e., a non-fixed contracture);

IV. Reasonable expectation of the ability to correct the contracture;

V. Contracture is interfering or expected to interfere significantly with the patient's functional abilities; and

VI. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons; or

VII. Member has plantar fasciitis.

(b) Replacement interface for AFO or KAFO is covered only if member continues to meet coverage criteria and is limited to a maximum of one (1) per six (6) months.

B. Cast Boot, Post-Operative Sandal or Shoe, or Healing Shoe. A cast boot, post-operative sandal or shoe, or healing shoe is covered for one (1) of the following indications:

(I) To protect a cast from damage during weight-bearing activities following injury or surgery;

(II) To provide appropriate support and/or weight-bearing surface to a foot following surgery;

(III) To promote good wound care and/or healing via appropriate weight distribution and foot protection; or

(IV) When the patient is currently receiving treatment for lymphedema and the foot cannot be fitted into conventional footwear.

C. Cranial Orthoses. Cranial orthosis is covered for Synostotic and Non-Synostotic Plagiocephaly. Plagiocephaly is an asymmetrically shaped head. Synostotic Plagiocephaly is due to premature closure of cranial sutures. Non-Synostotic Plagiocephaly is from positioning or deformation of the head. Cranial orthosis is the use of a special helmet or band on the head which aids in molding the shape of the cranium to normal. Initial reimbursement shall cover any subsequent revisions.

D. Elastic Supports. Elastic supports are covered when prescribed for one (1) of the following indications:

(I) Severe or incapacitating vascular problems, such as acute thrombophlebitis, massive venous stasis, or pulmonary embolism;

(II) Venous insufficiency;

(III) Varicose veins;

(IV) Edema of lower extremities;

(V) Edema during pregnancy; or

(VI) Lymphedema.

E. Footwear Incorporated Into a Brace for Members with Skeletally Mature Feet. Footwear incorporated into a brace must be billed by the same supplier billing for the brace. The following types of footwear incorporated into a brace are covered:

(I) Orthopedic footwear;

(II) Other footwear such as high top, depth inlay, or custom;

(III) Heel replacements, sole replacements, and shoe transfers involving shoes on a brace;

(IV) Inserts for a shoe that is an integral part of a brace and are required for the proper functioning of the brace; or

(V) Other shoe modifications if they are on a shoe that is an integral part of a brace and are required for the proper functioning of the brace.

F. Foot Orthoses. Custom, removable foot orthoses are covered for members who meet the following criteria:

(I) Member with skeletally mature feet who has any of the following conditions:

- (a) Acute plantar fasciitis;
- (b) Acute sport-related injuries with diagnoses related to inflammatory problems such as bursitis or tendonitis;
- (c) Calcaneal bursitis (acute or chronic);
- (d) Calcaneal spurs (heel spurs);
- (e) Conditions related to diabetes;
- (f) Inflammatory conditions (e.g., sesamoiditis, sub-metatarsal bursitis, synovitis, tenosynovitis, synovial cyst, osteomyelitis, and plantar fascial fibromatosis);
- (g) Medial osteoarthritis of the knee;
- (h) Musculoskeletal/arthropathic deformities including deformities of the joint or skeleton that impairs walking in a normal shoe (e.g., bunions, hallux valgus, talipes deformities, pes deformities, or anomalies of toes);

(i) Neurologically impaired feet including neuroma, tarsal tunnel syndrome, ganglionic cyst;

(j) Neuropathies involving the feet, including those associated with peripheral vascular disease, diabetes, carcinoma, drugs, toxins, and chronic renal disease; or

(k) Vascular conditions including ulceration, poor circulation, peripheral vascular disease, Buerger's disease (thromboangiitis obliterans), and chronic thrombophlebitis;

(II) Member with skeletally immature feet who has any of the following conditions:

- (a) Hallux valgus deformities;
- (b) In-toe or out-toe gait;
- (c) Musculoskeletal weakness such as pronation or pes planus;
- (d) Structural deformities such as tarsal coalitions; or
- (e) Torsional conditions such as metatarsus adductus, tibial torsion, or femoral torsion.

G. Helmets. Helmets are covered when cranial protection is required due to a documented medical condition that makes the member susceptible to injury during activities of daily living.

H. Hip Orthosis. Hip orthosis is covered for one (1) of the following indications:

- (I) To reduce pain by restricting mobility of the hip;
- (II) To facilitate healing following an injury to the hip or related soft tissues;
- (III) To facilitate healing following a surgical procedure of the hip or related soft tissue; or
- (IV) To otherwise support weak hip muscles or a hip deformity.

I. Knee Orthosis. Knee orthosis is covered for one (1) of the following indications:

- (I) To reduce pain by restricting mobility of the knee;
- (II) To facilitate healing following an injury to the knee or related soft tissues;
- (III) To facilitate healing following a surgical procedure on the knee or related soft tissue; or
- (IV) To otherwise support weak knee muscles or a knee deformity.

J. Orthopedic Footwear for Diabetic Members.

(I) Orthopedic footwear, therapeutic shoes, inserts, or modifications to therapeutic shoes are covered for diabetic members if any following criteria are met:

- (a) Previous amputation of the other foot or part of either foot;
- (b) History of previous foot ulceration of either foot;
- (c) History of pre-ulcerative calluses of either foot;

(d) Peripheral neuropathy with evidence of callus formation of either foot;

(e) Foot deformity of either foot; or

(f) Poor circulation in either foot.

(II) Coverage is limited to one (1) of the following within one (1) year:

(a) One (1) pair of custom molded shoes (which includes inserts provided with these shoes) and two (2) additional pairs of inserts;

(b) One (1) pair of depth shoes and three (3) pairs of inserts (not including the non-customized removable inserts provided with such shoes); or

(c) Up to three (3) pairs of inserts not dispensed with diabetic shoes if the supplier of the shoes verifies in writing that the patient has appropriate footwear into which the insert can be placed.

K. Orthotic-Related Supplies. Orthotic-related supplies are covered when necessary for the function of the covered orthotic device.

L. Spinal Orthoses. A thoracic-lumbar-sacral orthosis, lumbar orthosis, lumbar-sacral orthosis, and cervical orthosis are covered for the following indications:

- (I) To reduce pain by restricting mobility of the trunk;
- (II) To facilitate healing following an injury to the spine or related soft tissues;
- (III) To facilitate healing following a surgical procedure of the spine or related soft tissue; or
- (IV) To otherwise support weak spinal muscles or a deformed spine.

M. Trusses. Trusses are covered when a hernia is reducible with the application of a truss.

N. Upper Limb Orthosis. Upper limb orthosis is covered for the following indications:

- (I) To reduce pain by restricting mobility of the joint(s);
- (II) To facilitate healing following an injury to the joint(s) or related soft tissues; or
- (III) To facilitate healing following a surgical procedure of the joint(s) or related soft tissue.

O. Orthotic Device Replacement. When repairing an item that is no longer cost-effective and is out of warranty, the plan will consider replacing the item subject to review of medical necessity and life expectancy of the device;

[37./39. Preventive services.

A. Services recommended by the U.S. Preventive Services Task Force (categories A and B).

B. *[Immunizations]* **Vaccinations** recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

C. Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration.

D. Preventive care and screenings for women supported by the Health Resources and Services Administration.

E. Preventive exams and other services ordered as part of the exam. For benefits to be covered as preventive, they must be coded by the provider as routine, without indication of an injury or illness.

F. Cancer screenings. One (1) per calendar year. Additional screenings beyond one (1) per calendar year covered as diagnostic unless otherwise specified—

(I) Mammograms—no age limit. Standard two-dimensional (2D) breast mammography and breast tomosynthesis (three-dimensional (3D) mammography);

(II) Pap smears—no age limit;

(III) Prostate—no age limit; and

(IV) Colorectal screening—no age limit.

G. *[Zoster vaccination (shingles) — The zoster vaccine is covered for members age fifty (50) years and older]* **Online weight management program offered through the plan's exclusive provider arrangement;**

[38./40. Prostheses (prosthetic devices). Basic equipment that

meets medical needs. Repair and replacement is covered due to normal wear and tear, if there is a change in medical condition, or if growth-related;

[39.]41. Pulmonary rehabilitation. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and post-operative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

A. Member has a reduction of exercise tolerance that restricts the ability to perform activities of daily living (ADL) or work;

B. Member has chronic pulmonary disease (including asthma, emphysema, chronic bronchitis, chronic airflow obstruction, cystic fibrosis, alpha-1 antitrypsin deficiency, pneumoconiosis, asbestosis, radiation pneumonitis, pulmonary fibrosis, pulmonary alveolar proteinosis, pulmonary hemosiderosis, fibrosing alveolitis), or other conditions that affect pulmonary function such as ankylosing spondylitis, scoliosis, myasthenia gravis, muscular dystrophy, Guillain-Barré syndrome, or other infective polyneuritis, sarcoidosis, paralysis of diaphragm, or bronchopulmonary dysplasia; and

C. Member has a moderate to moderately severe functional pulmonary disability, as evidenced by either of the following, and does not have any concomitant medical condition that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g., symptomatic coronary artery disease, congestive heart failure, myocardial infarction within the last six (6) months, dysrhythmia, active joint disease, claudication, malignancy):

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake (VO_2max) equal to or less than twenty milliliters per kilogram per minute (20 mL/kg/min), or about five (5) metabolic equivalents (METS); or

(II) Pulmonary function tests showing that either the Forced Expiratory Volume in One Second (FEV1), Forced Vital Capacity (FVC), FEV1/FVC, or Diffusing Capacity of the Lung for Carbon Monoxide (DLCO) is less than sixty percent (60%) of that predicted;

[40.]42. Skilled Nursing Facility. Skilled nursing facility services are covered up to one hundred twenty (120) days per calendar year;

[41.]43. Telehealth Services. Telehealth services are covered for the diagnosis, consultation, or treatment of a member on the same basis that the service would be covered when it is delivered in person;

[42.]44. Therapy. Physical, occupational, and speech therapy are covered when prescribed by a provider and subject to the provisions below:

A. Physical therapy.

(I) Physical therapy must meet the following criteria:

(a) The program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, congenital defect, or surgery;

(b) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(c) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

B. Occupational therapy must meet the following criteria:

(I) The program is designed to improve or compensate for lost or impaired physical functions, particularly those affecting activities of daily living, resulting from illness, injury, congenital defect, or surgery;

(II) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(III) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

C. Speech therapy.

(I) All of the following criteria must be met for coverage of speech therapy:

(a) The therapy requires one-to-one intervention and supervision of a speech-language pathologist;

(b) The therapy plan includes specific tests and measures that will be used to document significant progress every two (2) weeks;

(c) Meaningful improvement is expected;

(d) The therapy includes a transition from one-to-one supervision to a self- or caregiver- provided maintenance program upon discharge; and

(e) One (1) of the following:

I. Member has severe impairment of speech-language; and an evaluation has been completed by a certified speech-language pathologist that includes age-appropriate standardized tests to measure the extent of the impairment, performance deviation, and language and pragmatic skill assessment levels; or

II. Member has a significant voice disorder that is the result of anatomic abnormality, neurological condition, or injury (e.g., vocal nodules or polyps, vocal cord paresis or paralysis, post-operative vocal cord surgery);

[43.]45. Transplants. Stem cell, kidney, liver, heart, lung, pancreas, small bowel, or any combination are covered. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements.

A. Network includes travel and lodging allowance for the transplant recipient and an immediate family travel companion when the transplant facility is more than fifty (50) miles from the recipient's residence. If the recipient is younger than age nineteen (19) years, travel and lodging is covered for both parents. The transplant recipient must be with the travel companion or parent(s) for the travel companion's or parent(s)' travel expense to be reimbursable. Combined travel and lodging expenses are limited to a ten thousand dollar (\$10,000) maximum per transplant.

(I) Lodging—maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to www.gsa.gov for per diem rates.

(II) Travel—IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).

(III) Meals—not covered.

B. Non-network. Charges above the maximum for services rendered at a non-network facility are the member's responsibility and do not apply to the member's deductible or out-of-pocket maximum. Travel, lodging, and meals are not covered;

[44.]46. Urgent care. Member encounter with a provider for urgent care is covered based on the service, procedure, or related treatment plan; and

[45.]47. Vision. One (1) routine exam and refraction is covered per calendar year.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Amended: Filed Oct. 31, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

PROPOSED RULE

22 CSR 10-3.058 PPO 750 Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 750 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

(1) Deductible—per calendar year for network: per individual, seven hundred fifty dollars (\$750); family, one thousand five hundred dollars (\$1,500) and for non-network: per individual, one thousand five hundred dollars (\$1,500); family, three thousand dollars (\$3,000).

(A) Network and non-network deductibles are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Claims will not be paid until the applicable deductible is met.

(C) Services that do not apply to the deductible and for which applicable costs will continue to be charged include, but are not limited to: copayments, charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(D) The family deductible is an embedded deductible with two (2) parts: an individual deductible and an overall family deductible. Each family member must meet his/her own individual deductible amount until the overall family deductible amount is reached. Once a family member meets his/her own individual deductible, the plan will start to pay claims for that individual and any additional out-of-pocket expenses incurred by that individual will not be used to meet the family deductible amount. Once the overall family deductible is met, the plan will start to pay claims for the entire family even if some family members have not met his/her own individual deductible.

(2) Coinsurance—coinsurance amounts apply to covered services after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(A) Network claims are paid at eighty percent (80%) until the out-of-pocket maximum is met.

(B) Non-network claims are paid at sixty percent (60%) until the out-of-pocket maximum is met.

(3) Out-of-pocket maximum—per calendar year for network: per individual, two thousand two hundred fifty dollars (\$2,250); family, four thousand five hundred dollars (\$4,500) and for non-network: per individual, four thousand five hundred dollars (\$4,500); family, nine thousand dollars (\$9,000).

(A) Network and non-network out-of-pocket maximums are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include, but are not limited to: charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(C) The family out-of-pocket maximum is an embedded out-of-pocket maximum with two (2) parts: an individual out-of-pocket maximum and an overall family out-of-pocket maximum. Each family member must meet his/her own individual out-of-pocket maximum amount until the overall family out-of-pocket maximum amount is reached. Once a family member meets his/her own individual out-of-pocket maximum, the plan will start to pay claims at one hundred percent (100%) for that individual. Once the overall family out-of-

pocket maximum is met, the plan will start to pay claims at one hundred percent (100%) for the entire family even if some family members had not met his/her own individual out-of-pocket maximum.

(4) The following services will be paid as a network benefit when provided by a non-network provider:

(A) Emergency services and urgent care;

(B) Covered services that are not available through a network provider within one hundred (100) miles of the member's home. The member must contact the claims administrator before the date of service in order to have a closer non-network provider's claims approved as a network benefit. Such approval is for three (3) months. After three (3) months, the member must contact the claims administrator to reassess network availability;

(C) Covered services when such services are provided in a network hospital or ambulatory surgical center and are an adjunct to a service being performed by a network provider. Examples of such adjunct services include, but are not limited to, anesthesiology, assistant surgeon, pathology, or radiology.

(5) The following services are not subject to deductible, coinsurance, or copayment requirements and will be paid at one hundred percent (100%) when provided by a network provider:

(A) Preventive care;

(B) Nutrition counseling;

(C) A newborn's initial hospitalization until discharge or transfer to another facility if the mother is a Missouri Consolidated Health Care Plan (MCHCP) member at the time of birth; and

(D) Four (4) Diabetes Self-Management Education/Training visits with a certified diabetes educator when ordered by a provider.

(6) Influenza vaccinations provided by a non-network provider will be reimbursed up to twenty-five dollars (\$25) once the member submits a receipt and a reimbursement form to the claims administrator.

(7) Married, active employees who are MCHCP subscribers and have enrolled children may meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must provide the other spouse's Social Security number (SSN) and report the other spouse as eligible for coverage when newly hired and during the open enrollment process. In the medical plan vendor and pharmacy benefit manager system, the spouse with children enrolled will be considered the subscriber and the spouse that does not have children enrolled will be considered a dependent. If both spouses have children enrolled the spouse with the higher Social Security number (SSN) will be considered the subscriber. Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

(8) Each subscriber will have access to payment information of the family unit only when authorization is granted by the adult covered dependent(s).

(9) Expenses toward the deductible and out-of-pocket maximum will be transferred if the member changes non-Medicare medical plans during the plan year or continues enrollment under another subscriber's non-Medicare medical plan within the same plan year.

(10) Copayments.

(A) Emergency room—two hundred fifty dollars (\$250) network and non-network. Deductible and coinsurance requirements apply to emergency room services in addition to the copayment. If a member is admitted to the hospital or the claims administrator considers the claim to be for a true emergency, the copayment is waived.

(B) Inpatient hospitalization—two hundred dollars (\$200) per admission for network and non-network. Deductible and coinsurance

requirements apply to inpatient hospitalization services in addition to the copayment.

(11) Maximum plan payment—non-network medical claims that are not otherwise subject to a contractual discount arrangement are processed at one hundred ten percent (110%) of Medicare reimbursement. Members may be held liable for the amount of the fee above the allowed amount.

(12) Any claim must be initially submitted within twelve (12) months following the date of service. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

(13) For a member who is an inpatient on the last calendar day of a plan year and remains an inpatient into the next plan year, the prior plan year's applicable copayment, deductible, and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

(14) Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-2.055. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as a non-network benefit. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

(15) Medicare.

(A) When MCHCP becomes aware that the member is eligible for Medicare benefits, claims will be processed reflecting Medicare coverage.

(B) If a member does not enroll in Medicare when s/he is eligible and Medicare should be the member's primary plan, the member will be responsible for paying the portion Medicare would have paid. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

(C) If a Medicare primary member chooses a provider who has opted out of Medicare, the member will be responsible for paying the portion Medicare would have paid if the service was performed by a Medicare provider. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Original rule filed Oct. 31, 2018.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

PROPOSED RULE

22 CSR 10-3.059 PPO 1250 Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 1250 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

(1) Deductible—per calendar year for network: per individual, one thousand two hundred fifty dollars (\$1,250); family, two thousand five hundred dollars (\$2,500) and for non-network: per individual, two thousand five hundred dollars (\$2,500); family, five thousand dollars (\$5,000).

(A) Network and non-network deductibles are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Claims will not be paid until the applicable deductible is met.

(C) Services that do not apply to the deductible and for which applicable costs will continue to be charged include, but are not limited to: copayments, charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(D) The family deductible is an embedded deductible with two (2) parts: an individual deductible and an overall family deductible. Each family member must meet his/her own individual deductible amount until the overall family deductible amount is reached. Once a family member meets his/her own individual deductible, the plan will start to pay claims for that individual and any additional out-of-pocket expenses incurred by that individual will not be used to meet the family deductible amount. Once the overall family deductible is met, the plan will start to pay claims for the entire family even if some family members have not met his/her own individual deductible.

(2) Coinsurance—coinsurance amounts apply to covered services after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(A) Network claims are paid at eighty percent (80%) until the out-of-pocket maximum is met.

(B) Non-network claims are paid at sixty percent (60%) until the out-of-pocket maximum is met.

(3) Out-of-pocket maximum—per calendar year for network: per individual, three thousand seven hundred fifty dollars (\$3,750); family, seven thousand five hundred dollars (\$7,500) and for non-network: per individual, seven thousand five hundred dollars (\$7,500); family, fifteen thousand dollars (\$15,000).

(A) Network and non-network out-of-pocket maximums are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include, but are not limited to: charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; non-covered services and charges above the maximum allowed.

(C) The family out-of-pocket maximum is an embedded out-of-pocket maximum with two (2) parts: an individual out-of-pocket maximum and an overall family out-of-pocket maximum. Each family member must meet his/her own individual out-of-pocket maximum amount until the overall family out-of-pocket maximum is reached. Once a family member meets his/her own individual out-of-pocket maximum, the plan will start to pay claims at one hundred percent (100%) for that individual. Once the overall family out-of-pocket maximum is met, the plan will start to pay claims at one hundred percent (100%) for the entire family even if some family members had not met his/her own individual out-of-pocket maximum.

(4) The following services will be paid as a network benefit when provided by a non-network provider:

(A) Emergency services and urgent care;

(B) Covered services that are not available through a network provider within one hundred (100) miles of the member's home. The member must contact the claims administrator before the date of service in order to have a closer non-network provider's claims approved as a network benefit. Such approval is for three (3) months. After three (3) months, the member must contact the claims administrator to reassess network availability; and

(C) Covered services when such services are provided in a network hospital or ambulatory surgical center and are an adjunct to a service being performed by a network provider. Examples of such adjunct services include, but are not limited to, anesthesiology, assistant surgeon, pathology, or radiology.

(5) The following services are not subject to deductible, coinsurance, or copayment requirements and will be paid at one hundred percent (100%) when provided by a network provider:

(A) Preventive care;

(B) Nutrition counseling;

(C) A newborn's initial hospitalization until discharge or transfer to another facility if the mother is a Missouri Consolidated Health Care Plan (MCHCP) member at the time of birth; and

(D) Four (4) Diabetes Self-Management Education/Training visits with a certified diabetes educator when ordered by a provider.

(6) Influenza vaccinations provided by a non-network provider will be reimbursed up to twenty-five dollars (\$25) once the member submits a receipt and a reimbursement form to the claims administrator.

(7) Married, active employees who are MCHCP subscribers and have enrolled children may meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must provide the other spouse's Social Security number (SSN) and report the other spouse as eligible for coverage when newly hired and during the open enrollment process. In the medical plan vendor and pharmacy benefit manager systems, the spouse with children enrolled will be considered the subscriber and the spouse that does not have children enrolled will be considered a dependent. If both spouses have children enrolled, the spouse with the higher Social Security number (SSN) will be considered the subscriber. Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

(8) Each subscriber will have access to payment information of the family unit only when authorization is granted by the adult covered dependent(s).

(9) Expenses toward the deductible and out-of-pocket maximum will be transferred if the member changes non-Medicare medical plans or continues enrollment under another subscriber's non-Medicare medical plan within the same plan year.

(10) Copayments. Copayments apply to network services unless otherwise specified.

(A) Office visit—primary care: twenty-five dollars (\$25); mental health: twenty-five dollars (\$25); specialist: forty dollars (\$40); chiropractor office visit and/or manipulation: the lesser of twenty dollars (\$20) or fifty percent (50%) of the total cost of services; urgent care: fifty dollars (\$50) network and non-network. All lab, X-ray, or other medical services associated with the office visit apply to the deductible and coinsurance.

(B) Emergency room—two hundred fifty dollars (\$250) network and non-network. Deductible and coinsurance requirements apply to emergency room services in addition to the copayment. If a member is admitted to the hospital or the claims administrator considers the claim to be for a true emergency, the copayment is waived.

(C) Inpatient hospitalization—two hundred dollars (\$200) per admission for network and non-network. Deductible and coinsurance requirements apply to inpatient hospitalization services in addition to the copayment.

(11) Maximum plan payment—non-network medical claims that are not otherwise subject to a contractual discount arrangement are allowed at one hundred ten percent (110%) of Medicare reimbursement. Members may be held liable for the amount of the fee above the allowed amount.

(12) Any claim must be initially submitted within twelve (12) months following the date of service. The plan reserves the right to deny claims not timely filed. A provider initiated correction to the originally filed claim must be submitted within the timeframe agreed in the provider contract, but not to exceed three hundred sixty-five (365) days from adjudication of the originally filed claim. Any claims reprocessed as primary based on action taken by Medicare or Medicaid must be initiated within three (3) years of the claim being incurred.

(13) For a member who is an inpatient on the last calendar day of a plan year and remains an inpatient into the next plan year, the prior plan year's applicable copayment, deductible, and/or coinsurance amounts will apply to the in-hospital facility and related ancillary charges until the member is discharged.

(14) Services performed in a country other than the United States may be covered if the service is included in 22 CSR 10-2.055. Emergency and urgent care services are covered as a network benefit. All other non-emergency services are covered as a non-network benefit. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

(15) Medicare.

(A) When MCHCP becomes aware that the member is eligible for Medicare benefits claims will be processed reflecting Medicare coverage.

(B) If a member does not enroll in Medicare when s/he is eligible and Medicare should be the member's primary plan, the member will be responsible for paying the portion Medicare would have paid. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

(C) If a Medicare primary member chooses a provider who has opted out of Medicare, the member will be responsible for paying the portion Medicare would have paid if the service was performed by a Medicare provider. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be

for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Original rule filed Oct. 31, 2018.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

PROPOSED RESCISSION

22 CSR 10-3.060 PPO 600 Plan, PPO 1000 Plan, and Health Savings Account Plan Limitations. This rule established the limitations and exclusions of the Missouri Consolidated Health Care Plan PPO 600 Plan, PPO 1000 Plan, and Health Savings Account Plan.

PURPOSE: This rule is being rescinded because the PPO 600 and PPO 1000 Plans will not be offered after December 31, 2018.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the *Code of State Regulations*. Emergency rescission filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Rescinded: Filed Oct. 31, 2018.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

PROPOSED RULE

22 CSR 10-3.061 Plan Limitations

PURPOSE: This rule establishes the policy of the board of trustees in regard to the PPO 750 Plan, PPO 1250 Plan, and Health Savings Account (HSA) Plan limitations of the Missouri Consolidated Health Care Plan.

(1) Benefits shall not be payable for, or in connection with, any medical benefits, services, or supplies which do not come within the definition of covered charges. In addition, the items specified in this rule are not covered unless expressly stated otherwise and then only to the extent expressly provided herein or in 22 CSR 10-3.057 or 22 CSR 10-3.090.

(A) Abortion—unless the life of the mother is endangered if the fetus is carried to term or due to death of the fetus.

(B) Acts of war including—injury or illness caused, or contributed to, by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.

(C) Alternative therapies—that are outside conventional medicine including, but not limited to, acupuncture, acupressure, homeopathy, hypnosis, massage therapy, reflexology, and biofeedback.

(D) Assistive listening device.

(E) Assistant surgeon services—unless determined to meet the clinical eligibility for coverage under the plan.

(F) Athletic enhancement services and sports performance training.

(G) Autopsy.

(H) Birthing center.

(I) Blood donor expenses.

(J) Blood pressure cuffs/monitors.

(K) Care received without charge.

(L) Charges exceeding the vendor contracted rate or benefit limit.

(M) Charges resulting from the failure to appropriately cancel a scheduled appointment.

(N) Childbirth classes.

(O) Comfort and convenience items.

(P) Cosmetic procedures.

(Q) Custodial or domiciliary care—including services and supplies that assist members in the activities of daily living such as walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet; preparation of special diets; supervision of medication that is usually self-administered; or other services that can be performed by persons who are not providers.

(R) Dental care, including oral surgery.

(S) Devices or supplies bundled as part of a service are not separately covered.

(T) Dialysis received through a non-network provider.

(U) Educational or psychological testing unless part of a treatment program for covered services.

(V) Examinations requested by a third party.

(W) Exercise equipment.

(X) Experimental/investigational/unproven services, procedures, supplies, or drugs as determined by the claims administrator.

(Y) Eye services and associated expenses for orthoptics, eye exercises, radial keratotomy, LASIK, and other refractive eye surgery.

(Z) Genetic testing based on family history alone, except for breast cancer susceptibility gene (BRCA) testing.

(AA) Health and athletic club membership—including costs of enrollment.

(BB) Hearing aid replacement batteries.

(CC) Home births.

(DD) Infertility treatment beyond the covered services to diagnose the condition.

(EE) Infusions received through a non-network provider.

(FF) Level of care, greater than is needed for the treatment of the illness or injury.

(GG) Long-term care.

(HH) Maxillofacial surgery.

(II) Medical care and supplies to the extent that they are payable under—

1. A plan or program operated by a national government or one

(1) of its agencies; or

2. Any state's cash sickness or similar law, including any group insurance policy approved under such law.

(JJ) Medical service performed by a family member—including a person who ordinarily resides in the subscriber's household or is related to the member, such as a spouse, parent, child, sibling, or brother/sister-in-law.

(KK) Military service-connected injury or illness—including expenses relating to Veterans Affairs or a military hospital.

(LL) Never events—never events on a list compiled by the National Quality Forum of inexcusable outcomes in a health care setting.

(MM) Nocturnal enuresis alarm.

(NN) Drugs that the pharmacy benefit manager (PBM) has excluded from the formulary and will not cover as a non-formulary drug unless it is approved in advance by the PBM.

(OO) Non-medically necessary services.

(PP) Non-provider allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning.

(QQ) Non-reusable disposable supplies.

(RR) Online weight management programs.

(SS) Other charges as follows:

1. Charges that would not otherwise be incurred if the subscriber was not covered by the plan;

2. Charges for which the subscriber or his/her dependents are not legally obligated to pay including, but not limited to, any portion of any charges that are discounted;

3. Charges made in the subscriber's name but which are actually due to the injury or illness of a different person not covered by the plan; and

4. No coverage for miscellaneous service charges including, but not limited to, charges for telephone consultations, administrative fees such as filling out paperwork or copy charges, or late payments.

(TT) Over-the-counter medications with or without a prescription including, but not limited to, analgesics, antipyretics, non-sedating antihistamines, unless otherwise covered as a preventive service.

(UU) Physical and recreational fitness.

(VV) Private-duty nursing.

(WW) Routine foot care without the presence of systemic disease that affects lower extremities.

(XX) Services obtained at a government facility if care is provided without charge.

(YY) Sex therapy.

(ZZ) Surrogacy—pregnancy coverage is limited to plan member.

(AAA) Telehealth site origination fees or costs for the provision of telehealth services are not covered.

(BBB) Therapy. Physical, occupational, and speech therapy are not covered for the following:

1. Physical therapy—

A. Treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Physical therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

E. Work hardening programs;

F. Back school;

G. Vocational rehabilitation programs and any program with the primary goal of returning an individual to work;

H. Group physical therapy (because it is not one-on-one, individualized to the specific person's needs); or

I. Services for the purpose of enhancing athletic or sports performance;

2. Occupational therapy—

A. Treatment provided to prevent or slow deterioration in

function or prevent reoccurrences;

B. Treatment intended to improve or maintain general physical condition;

C. Long-term rehabilitative services when significant therapeutic improvement is not expected;

D. Occupational therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., physical therapy);

E. Work hardening programs;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Group occupational therapy (because it is not one-on-one, individualized to the specific person's needs); and

H. Driving safety/driver training; and

3. Speech or voice therapy—

A. Any computer-based learning program for speech or voice training purposes;

B. School speech programs;

C. Speech or voice therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy);

D. Group speech or voice therapy (because it is not one-on-one, individualized to the specific person's needs);

E. Maintenance programs of routine, repetitive drills/exercises that do not require the skills of a speech-language therapist and that can be reinforced by the individual or caregiver;

F. Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work;

G. Therapy or treatment provided to prevent or slow deterioration in function or prevent reoccurrences;

H. Therapy or treatment provided to improve or enhance job, school, or recreational performance; and

I. Long-term rehabilitative services when significant therapeutic improvement is not expected.

(CCC) Travel expenses.

(DDD) Vaccinations requested by third party.

(EEE) Workers' Compensation services or supplies for an illness or injury eligible for, or covered by, any federal, state, or local government Workers' Compensation Act, occupational disease law, or other similar legislation.

AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Original rule filed Oct. 31, 2018.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

PROPOSED AMENDMENT

22 CSR 10-3.080 Miscellaneous Provisions. The Missouri

Consolidated Health Care Plan is amending section (5).

PURPOSE: This amendment revises the names of the medical plans.

(5) The PPO [600] 750 Plan, PPO [1000] 1250 Plan, and Health Savings Account Plan benefits including pharmacy are self-funded by the plan. MCHCP has subrogation rights under section 376.433, RSMo for any amounts expended for these benefits.

AUTHORITY: section 103.059, RSMo [2000] 2016. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. Amended: Filed Oct. 30, 2012, effective May 30, 2013. Amended: Filed Oct. 29, 2014, effective May 30, 2015. Amended: Filed Oct. 31, 2018.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED
HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership**

PROPOSED AMENDMENT

22 CSR 10-3.090 Pharmacy Benefit Summary. The Missouri Consolidated Health Care Plan is amending the purpose and section (1).

PURPOSE: This amendment revises the names of the medical plans, copayments, preventive drugs, and out-of-pocket maximum.

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Pharmacy Benefit Summary for the [PPO 600 Plan, PPO 1000 Plan] PPO 750 Plan, PPO 1250 Plan, Health Savings Account (HSA) Plan of the Missouri Consolidated Health Care Plan.

(1) The pharmacy benefit provides coverage for prescription drugs. Vitamin and nutrient coverage is limited to prenatal agents, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents as prescribed by a provider.

(A) PPO [600] 750 Plan and PPO [1000] 1250 Plan Prescription Drug Coverage.

1. Network.

A. Preferred formulary generic drug copayment: *[Eight dollars (\$8)] Ten Dollars (\$10)* for up to a thirty-one- (31-) day supply; *[sixteen dollars (\$16)] twenty dollars (\$20)* for up to a sixty- (60-) day supply; and *[twenty-four dollars (\$24)] thirty dollars (\$30)* for up to a ninety- (90-) day supply for a generic drug on the formulary; formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%).

B. Preferred formulary brand drug copayment: *[Thirty-five dollars (\$35)] Forty dollars (\$40)* for up to a thirty-one- (31-) day supply; *[seventy dollars (\$70)] eighty dollars (\$80)* for up to a sixty- (60-) day supply; and *[one hundred and five dollars (\$105)] one hundred twenty dollars (\$120)* for up to a ninety- (90-) day sup-

ply for a brand drug on the formulary; formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%).

C. Non-preferred formulary drug and approved excluded drug copayment: One hundred dollars (\$100) for up to a thirty-one- (31-) day supply; two hundred dollars (\$200) for up to a sixty- (60-) day supply; and three hundred dollars (\$300) for up to a ninety- (90-) day supply for a drug not on the formulary.

D. Specialty drug (as designated as such by the PBM) copayment: Seventy-five dollars (\$75) for up to a thirty-one- (31-) day supply for a specialty drug on the formulary;

[D.]E. Diabetic drug (as designated as such by the PBM) copayment: [f]Fifty percent (50%) of the applicable network copayment.

[E.]F. Home delivery programs.

(I) Maintenance prescriptions may be filled through the pharmacy benefit manager's (PBM's) home delivery program. A member must choose how maintenance prescription(s) will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

(a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision and the amount charged will not apply to the out-of-pocket maximum.

(b) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM.

(II) Specialty drugs are covered only through the specialty home delivery network for up to a thirty-one- (31-) day supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. All specialty prescriptions must be filled through the PBM's specialty pharmacy, unless the prescription is identified by the PBM as emergent. The first fill of a specialty prescription may be filled through a retail pharmacy.

(a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply with a prorated copayment. If the member is able to continue with the medication, the remaining supply will be shipped with the remaining portion of the copayment. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment.

(III) Prescriptions filled through home delivery programs have the following copayments:

(a) Preferred formulary generic drug copayments: *[Eight dollars (\$8)] Ten dollars (\$10)* for up to a thirty-one- (31-) day supply; *[sixteen dollars (\$16)] twenty dollars (\$20)* for up to a sixty- (60-) day supply; and twenty dollars (\$20) for up to a ninety- (90-) day supply for a generic drug on the formulary;

(b) Preferred formulary brand drug copayments: *[Thirty-five dollars (\$35)] Forty dollars (\$40)* for up to a thirty-one- (31-) day supply; *[seventy dollars (\$70)] eighty dollars (\$80)* for up to a sixty- (60-) day supply; and *[eighty-seven dollars and fifty cents (\$87.50)] one hundred dollars (\$100)* for up to a ninety- (90-) day supply for a brand drug on the formulary;

(c) Non-preferred formulary drug and approved excluded drug copayments: One hundred dollars (\$100) for up to a thirty-one- (31-) day supply; two hundred dollars (\$200) for up to a sixty- (60-) day supply; and two hundred fifty dollars (\$250) for up to a ninety- (90-) day supply for a drug not on the formulary.

(D) Specialty drug (as designated as such by the PBM) copayment: Seventy-five dollars (\$75) for up to a thirty-one- (31-) day supply for a specialty drug on the formulary;

/F./G. Diabetic drug (as designated as such by the PBM) copayment: */f/F*ifty percent (50%) of the applicable network copayment.

/G./H. Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount.

/H./I. The copayment for a compound drug is based on the primary drug in the compound. The primary drug in a compound is the most expensive prescription drug in the mix. If any ingredient in the compound is excluded by the plan, the compound will be denied.

/I./J. If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug.

/J./K. If the physician allows for generic substitution and the member chooses a brand-name drug, the member is responsible for the generic copayment and the cost difference between the brand-name and generic drug which shall not apply to the out-of-pocket maximum.

L. Preferred select brand drugs, as determined by the PBM: Ten dollars (\$10) for up to a thirty-one- (31-) day supply; twenty dollars (\$20) for up to a sixty- (60-) day supply; and twenty-five dollars (\$25) for up to a ninety- (90-) day supply;

/K./M. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy. The following are also covered at one hundred percent (100%) when filled at a network pharmacy:

[(I)] Prescribed Vitamin D for all ages;

(a) The range for preventive Vitamin D at or below 1000 IU of Vitamin D₂ or D₃ per dose;

(II) Zoster (shingles) vaccine and administration for members age fifty (50) years and older;]

[(III)](I) [Influenza v/Vaccine [and administration as] recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

[(IV)](II) Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer;

[(V)](III) Prescribed preferred diabetic test strips and lancets; and

[(VI)](IV) One (1) preferred glucometer.

2. Non-network: If a member chooses to use a non-network pharmacy for non-specialty prescriptions, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable network copayment.

3. Out-of-pocket maximum.

A. Network and non-network out-of-pocket maximums are separate.

B. The family out-of-pocket maximum is an aggregate of applicable charges received by all covered family members of the plan. Any combination of covered family member applicable charges may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.

/C. PPO 600 Individual—five thousand one hundred dollars (\$5,100).

D. PPO 600 Family—ten thousand two hundred dollars (\$10,200).

E. PPO 1000 Individual—two thousand one hundred dollars (\$2,100).

F. PPO 1000 Family—four thousand two hundred dollars (\$4,200).]

C. Network individual—four thousand one hundred fifty dollars (\$4,150).

D. Network family—eight thousand three hundred dollars (\$8,300).

E. Non-network—no maximum.

(B) Health Savings Account (HSA) Plan Prescription Drug

Coverage. Medical and pharmacy expenses are combined to apply toward the appropriate network or non-network deductible and out-of-pocket maximum specified in 22 CSR 10-3.055.

1. Network.

A. Preferred formulary generic drug: Ten percent (10%) coinsurance after deductible for a generic drug on the formulary.

B. Preferred formulary brand drug: Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary.

C. Non-preferred formulary drug and approved excluded drug: Forty percent (40%) coinsurance after deductible for a drug not on the formulary.

D. Diabetic drug (as designated by the PBM) coinsurance: */f/F*ifty percent (50%) of the applicable network coinsurance after deductible has been met.

E. Home delivery program.

(I) Maintenance prescriptions may be filled through the PBM's home delivery program. A member must choose how maintenance prescriptions will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

(a) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision.

(b) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM.

(II) Specialty drugs are covered only through network home delivery for up to a thirty-one- (31-) day supply unless the PBM has determined that the specialty drug is eligible for up to a ninety- (90-) day supply. All specialty prescriptions must be filled through the PBM's specialty pharmacy, unless the prescription is identified by the PBM as emergent. The first fill of a specialty prescription identified to be emergent, may be filled through a retail pharmacy.

(a) Specialty split-fill program—The specialty split-fill program applies to select specialty drugs as determined by the PBM. For the first three (3) months, members will be shipped a fifteen- (15-) day supply. If the member is able to continue with the medication, the remaining supply will be shipped. Starting with the fourth month, an up to thirty-one- (31-) day supply will be shipped if the member continues on treatment.

F. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) and, for women, by the Health Resources and Services Administration are covered at one hundred percent (100%) when filled at a network pharmacy. The following are also covered at one hundred percent (100%) when filled at a network pharmacy:

[(I)] Prescribed Vitamin D for all ages.

(a) The range for preventive Vitamin D is at or below 1000 IU of Vitamin D₂ or D₃ per dose;

(II) Zoster (shingles) vaccine and administration for members age fifty (50) years and older;]

[(III)](I) [Influenza v/Vaccines and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

[(IV)](II) Generic Tamoxifen, generic Raloxifene, and brand Soltamox for prevention of breast cancer;

G. The following are covered at one hundred percent (100%) after deductible is met and when filled at a network pharmacy:

(I) Prescribed preferred diabetic test strips and lancets; and

(II) One (1) preferred glucometer.

H. If any ingredient in a compound drug is excluded by the plan, the compound will be denied.

2. Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable deductible or coinsurance.

A. Preferred formulary generic drug: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a generic drug on the formulary.

B. Preferred formulary brand drug: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a brand drug on the formulary.

C. Non-preferred formulary drug and approved excluded drug: Fifty percent (50%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a drug not on the formulary.

D. Diabetic drug (as designated by the PBM) coinsurance: ~~/f/~~Fifty percent (50%) of the applicable non-network coinsurance after deductible has been met.

*AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Oct. 31, 2018, effective Jan. 1, 2019, expires June 29, 2019. Amended: Filed Oct. 31, 2018.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

This section will contain the final text of the rules proposed by agencies. The order of rulemaking is required to contain a citation to the legal authority upon which the order or rulemaking is based; reference to the date and page or pages where the notice of proposed rulemaking was published in the *Missouri Register*; an explanation of any change between the text of the rule as contained in the notice of proposed rulemaking and the text of the rule as finally adopted, together with the reason for any such change; and the full text of any section or subsection of the rule as adopted which has been changed from that contained in the notice of proposed rulemaking. The effective date of the rule shall be not less than thirty (30) days after the date of publication of the revision to the *Code of State Regulations*.

The agency is also required to make a brief summary of the general nature and extent of comments submitted in support of or opposition to the proposed rule and a concise summary of the testimony presented at the hearing, if any, held in connection with the rulemaking, together with a concise summary of the agency's findings with respect to the merits of any such testimony or comments which are opposed in whole or in part to the proposed rule. The ninety-(90-) day period during which an agency shall file its order of rulemaking for publication in the *Missouri Register* begins either: 1) after the hearing on the proposed rulemaking is held; or 2) at the end of the time for submission of comments to the agency. During this period, the agency shall file with the secretary of state the order of rulemaking, either putting the proposed rule into effect, with or without further changes, or withdrawing the proposed rule.

**Title 2—DEPARTMENT OF AGRICULTURE
Division 60—Grain Inspection and Warehousing
Chapter 1—Organization and Description**

ORDER OF RULEMAKING

By the authority vested in the Director of the Department of Agriculture under section 536.023, RSMo 2016, the director amends a rule as follows:

2 CSR 60-1.010 General Organization is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 2, 2018 (43 MoReg 1419-1420). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 2—DEPARTMENT OF AGRICULTURE
Division 60—Grain Inspection and Warehousing
Chapter 2—Grain Sampling**

ORDER OF RULEMAKING

By the authority vested in the Director of the Department of Agriculture under section 536.023, RSMo 2016, the director rescinds a rule as follows:

2 CSR 60-2.010 Grain Sampling is rescinded.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on July 2, 2018 (43 MoReg 1420). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 2—DEPARTMENT OF AGRICULTURE
Division 60—Grain Inspection and Warehousing
Chapter 4—Missouri Grain Warehouse Law**

ORDER OF RULEMAKING

By the authority vested in the Director of the Department of Agriculture under section 536.023, RSMo 2016, the director rescinds a rule as follows:

2 CSR 60-4.016 Application of Law is rescinded.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on July 2, 2018 (43 MoReg 1420). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 2—DEPARTMENT OF AGRICULTURE
Division 60—Grain Inspection and Warehousing
Chapter 4—Missouri Grain Warehouse Law**

ORDER OF RULEMAKING

By the authority vested in the Director of the Department of Agriculture under section 536.023, RSMo 2016, the director rescinds a rule as follows:

2 CSR 60-4.045 Weighing of Grain is rescinded.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on July 2, 2018 (43 MoReg 1420). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 2—DEPARTMENT OF AGRICULTURE
Division 60—Grain Inspection and Warehousing
Chapter 4—Missouri Grain Warehouse Law**

ORDER OF RULEMAKING

By the authority vested in the Director of the Department of Agriculture under section 536.023, RSMo 2016, the director rescinds a rule as follows:

2 CSR 60-4.060 Safety Requirements is rescinded.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on July 2, 2018 (43 MoReg 1420-1421). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 2—DEPARTMENT OF AGRICULTURE
Division 60—Grain Inspection and Warehousing
Chapter 4—Missouri Grain Warehouse Law**

ORDER OF RULEMAKING

By the authority vested in the Director of the Department of Agriculture under section 536.023, RSMo 2016, the director rescinds a rule as follows:

**2 CSR 60-4.070 Notification of Destruction or Damage to Grain
is rescinded.**

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on July 2, 2018 (43 MoReg 1421). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 2—DEPARTMENT OF AGRICULTURE
Division 60—Grain Inspection and Warehousing
Chapter 4—Missouri Grain Warehouse Law**

ORDER OF RULEMAKING

By the authority vested in the Director of the Department of Agriculture under section 536.023, RSMo 2016, the director amends a rule as follows:

2 CSR 60-4.080 Storage Space Approval is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 2, 2018 (43 MoReg 1421). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 2—DEPARTMENT OF AGRICULTURE
Division 60—Grain Inspection and Warehousing
Chapter 4—Missouri Grain Warehouse Law**

ORDER OF RULEMAKING

By the authority vested in the Director of the Department of Agriculture under section 536.023, RSMo 2016, the director rescinds a rule as follows:

2 CSR 60-4.090 Scale Tickets is rescinded.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on July 2, 2018 (43 MoReg 1421). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 2—DEPARTMENT OF AGRICULTURE
Division 60—Grain Inspection and Warehousing
Chapter 4—Missouri Grain Warehouse Law**

ORDER OF RULEMAKING

By the authority vested in the Director of the Department of Agriculture under section 536.023, RSMo 2016, the director amends a rule as follows:

2 CSR 60-4.120 Tariffs is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 2, 2018 (43 MoReg 1422). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 2—DEPARTMENT OF AGRICULTURE
Division 60—Grain Inspection and Warehousing
Chapter 4—Missouri Grain Warehouse Law**

ORDER OF RULEMAKING

By the authority vested in the Director of the Department of Agriculture under section 536.023, RSMo 2016, the director amends a rule as follows:

**2 CSR 60-4.130 Acceptance of Appraisal Values on Financial
Statements is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 2, 2018 (43 MoReg 1422). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 2—DEPARTMENT OF AGRICULTURE
Division 60—Grain Inspection and Warehousing
Chapter 4—Missouri Grain Warehouse Law**

ORDER OF RULEMAKING

By the authority vested in the Director of the Department of Agriculture under section 536.023, RSMo 2016, the director amends a rule as follows:

2 CSR 60-4.170 Insurance Deductible is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 2, 2018 (43 MoReg 1422). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 2—DEPARTMENT OF AGRICULTURE
Division 60—Grain Inspection and Warehousing
Chapter 5—Missouri Grain Dealer's Law**

ORDER OF RULEMAKING

By the authority vested in the Director of the Department of Agriculture under section 536.023, RSMo 2016, the director rescinds a rule as follows:

2 CSR 60-5.040 Daily Position Record is rescinded.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on July 2, 2018 (43 MoReg 1422). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 5—DEPARTMENT OF ELEMENTARY AND
SECONDARY EDUCATION
Division 20—Division of Learning Services
Chapter 300—Office of Special Education**

ORDER OF RULEMAKING

By the authority vested in the State Board of Education (board) under section 161.092, RSMo 2016, the board rescinds a rule as follows:

5 CSR 20-300.140 Extraordinary Cost Fund is rescinded.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on August 1, 2018 (43 MoReg 2013-2014). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 5—DEPARTMENT OF ELEMENTARY AND
SECONDARY EDUCATION
Division 20—Division of Learning Services
Chapter 400—Office of Educator Quality**

ORDER OF RULEMAKING

By the authority vested in the State Board of Education (board) under sections 161.092, 168.011, 168.071, 168.081, 168.400, 168.405, and 168.409, RSMo 2016, and section 168.021, RSMo Supp. 2018, the board amends a rule as follows:

5 CSR 20-400.510 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 1, 2018 (43 MoReg 2014). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received one (1) comment on this proposed amendment.

COMMENT #1: Steven Beldin on behalf of the Missouri Council of Administrators of Special Education (MO-CASE) suggested additional language be added to part (1)(B)4.B.(I).

RESPONSE AND EXPLANATION OF CHANGE: Based upon the comment received, amended part to (1)(B)4.B.(I). to include explicit and systematic instruction.

**5 CSR 20-400.510 Certification Requirements for Teacher of
Early Childhood Education (Birth – Grade 3)**

(1) An applicant for a Missouri certificate of license to teach Early Childhood Education (Birth – Grade 3) who possesses good moral character may be granted an initial Missouri certificate of license to teach Early Childhood Education (Birth – Grade 3) subject to the certification requirements found in 5 CSR 20-400.500 and the following additional certification requirements specific to Early Childhood Education (Birth – Grade 3):

(B) Professional Requirements. A minimum of sixty (60) semester hours of professional preparation. Competency must be demonstrated to the satisfaction of the educator preparation program for the following topics:

1. Content Planning and Delivery. Candidates are prepared with a deep knowledge of and understand the relationships among curriculum, instruction, and assessment—

A. Curriculum and Instructional Planning;

B. Instructional Strategies and Techniques in Content Area

Specialty;

C. Assessment, Student Data, and Data-Based Decision-Making;

D. Strategies for Content Literacy;

E. Critical Thinking and Problem Solving;

F. English Language Learning;

2. Individual Student Needs. Candidates build a robust knowledge of learners and the learning environment—

A. Psychological Development of the Child and Adolescent;

B. Psychology/Education of the Exceptional Child;

C. Differentiated Learning;

D. Classroom Management;

E. Cultural Diversity;

F. Educational Psychology;

3. Schools and the Teaching Profession. Candidates fully understand the role of schools and schooling as well as the professional responsibilities of teachers, including a means of professional growth—

A. Consultation and Collaboration;

B. Legal/Ethical Aspects of Teaching;

4. Content Knowledge for Teaching and Teaching and Learning Strategies for the Young Child (minimum requirement of thirty (30) semester hours)—

A. Early Childhood Principles:

(I) Child Development;

(II) Play-Based and Inquiry-Based Learning;

(III) Observing and Assessing Young Children;

(IV) Language Acquisition;

B. Methods of Teaching and Differentiated Instruction in the following integrated areas:

(I) Early Literacy (minimum of six (6) semester hours) to address curriculum, explicit and systematic instruction, and assessment of—

(a) Language acquisition;

- (b) Phonological and phonemic awareness;
- (c) Phonics;
- (d) Vocabulary;
- (e) Fluency;
- (f) Comprehension; and
- (g) Writing process using authentic text and purposes;
- (II) Math;
- (III) Health;
- (IV) Science;
- (V) Nutrition;
- (VI) Social Studies;
- (VII) Music;
- (VIII) Safety;
- (IX) Movement;
- (X) Art; and
- (XI) Drama;
- 5. Home-School-Community Relations (minimum requirement of six (6) semester hours)—
 - A. Families as Educational Partners;
 - B. Family Engagement; and
 - C. Linking Families with Community Resources;
- 6. Program Management (minimum requirement of six (6) semester hours)—
 - A. Program Administration and Management;
 - B. Health, Nutrition, and Safety of Young Children; and
 - C. Environmental Organization and Design; and

Title 5—DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION

Division 20—Division of Learning Services Chapter 400—Office of Educator Quality

ORDER OF RULEMAKING

By the authority vested in the State Board of Education (board) under sections 161.092, 168.011, 168.071, 168.081, 168.400, 168.405, and 168.409, RSMo 2016, and section 168.021, RSMo Supp. 2018, the board amends a rule as follows:

5 CSR 20-400.520 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 1, 2018 (43 MoReg 2015–2016). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received one (1) comment on this proposed amendment.

COMMENT #1: Steven Beldin on behalf of the Missouri Council of Administrators of Special Education (MO-CASE) suggested additional language be added to part (1)(B)4.A.(I).

RESPONSE AND EXPLANATION OF CHANGE: Based upon the comment received, amended part to (1)(B)4.B.(I) to include explicit and systematic instruction.

5 CSR 20-400.520 Certification Requirements for Teacher of Elementary Education (Grades 1-6)

(1) An applicant for a Missouri certificate of license to teach Elementary Education (Grades 1-6) who possesses good moral character may be granted an initial Missouri certificate of license to teach Elementary Education (Grades 1-6) subject to the certification requirements found in 5 CSR 20-400.500 and the following additional certification requirements specific to Elementary Education (Grades 1-6):

- (B) Professional Requirements. A minimum of thirty-six (36)

semester hours of professional preparation. Competency must be demonstrated to the satisfaction of the educator preparation program for the following topics:

1. Content Planning and Delivery. Candidates are prepared with a deep knowledge of and understand the relationships among curriculum, instruction, and assessment—

- A. Curriculum and Instructional Planning;
- B. Instructional Strategies and Techniques in Content Area Specialty;
- C. Assessment, Student Data, and Data-Based Decision-Making;
- D. Strategies for Content Literacy;
- E. Critical Thinking and Problem Solving; and
- F. English Language Learning;

2. Individual Student Needs. Candidates build a robust knowledge of learners and the learning environment—

- A. Psychological Development of the Child and Adolescent;
- B. Psychology/Education of the Exceptional Child;
- C. Differentiated Learning;
- D. Classroom Management;
- E. Cultural Diversity; and
- F. Education Psychology;

3. Schools and the Teaching Profession. Candidates fully understand the role of schools and schooling as well as the professional responsibilities of teachers, including a means of professional growth—

- A. Consultation and Collaboration; and
- B. Legal/Ethical Aspects of Teaching;

4. Content Knowledge for Teaching and Teaching and Learning Strategies (minimum requirement of twenty-one (21) semester hours)—

A. At a minimum, the teaching method competencies shall include:

(I) Elementary Literacy (minimum total of twelve (12) semester hours)—to address curriculum, explicit and systematic instruction, and assessment of—

- (a) Language acquisition;
- (b) Phonological and phonemic awareness;
- (c) Phonics;
- (d) Vocabulary;
- (e) Fluency;
- (f) Comprehension; and
- (g) Writing process using authentic text and purposes;

(II) Mathematics (minimum of six (6) total semester hours);

- (III) Science; and
- (IV) Social Science;

B. Integration of the following areas:

- (I) Art;
- (II) Music;
- (III) Health and Physical Education; and
- (IV) Technology in Education; and

Title 5—DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION

Division 20—Division of Learning Services Chapter 400—Office of Educator Quality

ORDER OF RULEMAKING

By the authority vested in the State Board of Education (board) under sections 161.092, 168.011, 168.071, 168.081, 168.400, 168.405, and 168.409, RSMo 2016, and section 168.021, RSMo Supp. 2018, the board amends a rule as follows:

5 CSR 20-400.560 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 1, 2018 (43 MoReg 2016–2017). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received one (1) comment on this proposed amendment.

COMMENT #1: Steven Beldin on behalf of the Missouri Council of Administrators of Special Education (MO-CASE) suggested additional language be added to part (4)(A)4.B.(I) and subparagraph (5)(A)4.A.

RESPONSE AND EXPLANATION OF CHANGE: Based upon the comment received, amended part (4)(A)4.B.(I) and subparagraph (5)(A)4.A to include explicit and systematic instruction.

5 CSR 20-400.560 Certification Requirements for Teacher of Special Education

(4) An applicant for a Missouri certificate to teach Early Childhood Special Education (Birth – Grade 3) who possesses a baccalaureate degree from a college or university having an educator preparation program approved by the department, or from a college or university having an education program approved by the state education agency in states other than Missouri may be granted an initial Missouri certificate of license to teach Early Childhood Special Education (Birth – Grade 3) subject to the certification requirements found in 5 CSR 20-400.500 and the following additional certification requirements:

(A) Professional Requirements. A minimum of sixty (60) semester hours of professional preparation. Competency must be demonstrated to the satisfaction of the educator preparation institution for each topic listed.

1. Content Planning and Delivery. Candidates are prepared with a deep knowledge of and understand the relationship among curriculum, instruction, and assessment—

- A. Curriculum and Instructional Planning;
- B. Instructional Strategies and Techniques in Content Area Specialty;
- C. Assessment, Student Data, and Data-Based Decision-Making;
- D. Critical Thinking and Problem Solving;
- E. English Language Learning; and
- F. Evaluation of Abilities and Achievement (instruction in interpretation of individualized, formative, and summative assessments, eligibility procedures, and assessment to support evidence-based instruction).

2. Individual Student Needs. Candidates build a robust knowledge of learners and the learning environment—

- A. Psychological Development of the Child and Adolescent;
- B. Psychology/Education of the Exceptional Child;
- C. Differentiated Learning;
- D. Classroom Management;
- E. Behavior Intervention Strategies;
- F. Cultural Diversity; and
- G. Educational Psychology.

3. Schools and the Teaching Profession. Candidates fully understand the role of schools and schooling as well as the professional responsibilities of teachers, including a means of professional growth—

- A. Consultation and Collaboration;
- B. Legal/Ethical Aspects of Teaching;
- C. Tiered Systems for Supporting Instruction and Behavior;
- D. Families as Educational Partners;
- E. Family Engagement;
- F. Linking Families with Resources; and
- G. Individualized Education Plans and the Special Education Process.

4. Teaching and Supporting Learning of the Young Child—

- A. Early Childhood Principles;

- (I) Child Development;
- (II) Play-Based and Inquiry-Based Learning;
- (III) Observing and Assessing Young Children;
- (IV) Language Acquisition; and
- (V) Alternative and Augmentative Communication;

B. Methods of Teaching and Differentiated Instruction in the following integrated areas (minimum requirement of fifteen (15) hours):

(I) Early Literacy (minimum of six (6) semester hours) to address curriculum, explicit and systematic instruction, and assessment of—

- (a) Language acquisition;
- (b) Phonological and phonemic awareness;
- (c) Phonics;
- (d) Vocabulary;
- (e) Fluency;
- (f) Comprehension; and
- (g) Writing process using authentic text and purposes;

(II) Math;

(III) Health;

(IV) Science;

(V) Nutrition;

(VI) Social Studies;

(VII) Music;

(VIII) Safety;

(IX) Movement;

(X) Art;

(XI) Drama; and

(XII) Instructional and Assistive Technology;

5. Program Management—

- A. Program Administration and Management;
- B. Health, Nutrition, and Safety of Young Children;
- C. Environmental Organization and Design; and
- D. Procedural Safeguards;

(5) An applicant for a Missouri certificate of license to teach students with Mild/Moderate Cross-Categorical Disabilities (Kindergarten – Grade 12) who possesses a baccalaureate degree in Special Education from a college or university having an educator preparation program approved by the department or from a college or university having an educator preparation program approved by the state agency in states other than Missouri may be granted an initial Missouri certificate of license to teach students with Mild/Moderate Cross-Categorical Disabilities (Kindergarten – Grade 12) subject to the certification requirements found in 5 CSR 20-400.500 and the following additional certification requirements:

(A) Professional Requirements. A minimum of sixty (60) semester hours of professional preparation. Competency must be demonstrated to the satisfaction of the educator preparation institution for each topic listed—

1. Content Planning and Delivery. Candidates are prepared with a deep knowledge of and understand the relationships among curriculum, instruction, and assessment—

- A. Curriculum and Instructional Planning;
- B. Instructional Strategies and Techniques in Content Area Specialty;
- C. Assessment, Student Data, and Data-Based Decision-Making;

D. Strategies for Content Literacy;

E. Critical Thinking and Problem Solving;

F. English Language Learning;

G. Evaluation of Abilities and Achievement (instruction in interpretation of individualized, formative, and summative assessments, eligibility procedures, and assessment to support evidence-based instruction);

H. Transition Processes, including Career Education or Career Readiness; and

2. Individual Student Needs. Candidates build a robust knowledge of learners and the learning environment—

- A. Psychological Development of the Child and Adolescent;
- B. Psychology/Education of the Exceptional Child;
- C. Differentiated Learning;
- D. Classroom Management;
- E. Behavior Intervention Strategies;
- F. Cultural Diversity;
- G. Educational Psychology; and
- H. Language Development of the Exceptional Child;

3. Schools and the Teaching Profession. Candidates fully understand the role of schools and schooling as well as the professional responsibilities of teachers, including a means of professional growth—

- A. Consultation and Collaboration;
- B. Legal/Ethical Aspects of Teaching;
- C. Tiered Systems for Supporting Instruction and Behavior;
- D. Families as Educational Partners;
- E. Family Engagement;
- F. Linking Families with Resources; and
- G. Individualized Education Plans and the Special Education

Process;

4. Teaching and Learning Strategies—

A. Literacy (a minimum total of twelve (12) semester hours) to address specialized instruction in curriculum, explicit and systematic instruction, assessment, and intensive intervention of—

- (I) Language acquisition;
- (II) Phonological and phonemic awareness;
- (III) Phonics;
- (IV) Vocabulary;
- (V) Fluency;
- (VI) Comprehension; and
- (VII) Writing process using authentic text and purposes;

B. Science;

C. Social Science;

D. Instructional and Assistive Technology; and

E. Mathematics (two (2) courses required, minimum of six (6) total semester hours) to include instructional interventions for students with mathematics deficits; and

Title 5—DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION

Division 20—Division of Learning Services Chapter 400—Office of Educator Quality

ORDER OF RULEMAKING

By the authority vested in the State Board of Education (board) under sections 161.092, 168.011, 168.071, 168.081, 168.400, 168.405, and 168.409, RSMo 2016, and section 168.021, RSMo Supp. 2018, the board amends a rule as follows:

5 CSR 20-400.640 Certification Requirements for Initial Student Services Certificate is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 1, 2018 (43 MoReg 2017-2020). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received two (2) comments on this proposed amendment. Both comments were related to the School Psychological Examiner.

COMMENT #1: Michele Augustin on behalf of the Missouri Association of School Psychologist (MASP) offered suggestions for the School Psychological Examiner certificate in regards to addition-

al internship requirements and discontinuing the issuance of this certificate.

RESPONSE: No changes have been made to the amendment as a result of this comment.

COMMENT #2: Steven Beldin on behalf of the Missouri Council of Administrators of Special Education (MO-CASE) recommended discontinuing the issuance of the School Psychological Examiner certificate.

RESPONSE: No changes have been made to the amendment as a result of this comment.

Title 10—DEPARTMENT OF NATURAL RESOURCES Division 10—Air Conservation Commission Chapter 2—Air Quality Standards and Air Pollution Control Rules Specific to the Kansas City Metropolitan Area

ORDER OF RULEMAKING

By the authority vested in the Missouri Air Conservation Commission under section 643.050, RSMo 2016, the commission rescinds a rule as follows:

10 CSR 10-2.215 Control of Emissions From Solvent Cleanup Operations is rescinded.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on May 15, 2018 (43 MoReg 1015-1016). No changes were made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Air Pollution Control Program received twelve (12) comments on this rulemaking from the U.S. Environmental Protection Agency (EPA).

Due to similar concerns expressed in the following five (5) comments, one (1) response that addresses these concerns is at the end of these five (5) comments.

COMMENT #1: The EPA provided a general comment for all the rules that the department has the responsibility to ensure that the State Implementation Plan (SIP) revision submitted to EPA meets the requirements of sections 110(1) and 193 of the Clean Air Act (CAA).

Section 110(1): Generally, section 110(1) provides that EPA cannot approve a SIP revision if the revision interferes with any applicable requirement concerning attainment and reasonable further progress or any other requirement of the CAA. This section applies to any area and to any National Ambient Air Quality Standard (NAAQS) pollutant and/or precursor. Thus, any SIP rule is subject to this section.

Section 193: Section 193 prohibits modification of a SIP in effect before 1990 unless that modification would ensure equivalent or greater emissions reductions, i.e., "anti-backsliding." Section 193 applies only to nonattainment areas and is specific to the nonattainment pollutant. The applicability of section 193 is specific to nonattainment "criteria" pollutants. The ozone implementation rule (codified at 40 CFR 51.905(a)(4)), describes how section 193 applies to Kansas City - an attainment area for the eight (8)-hour standard and maintenance area for the one (1)-hour standard.

Each of the eleven (11) proposed rule rescissions are subject to section 110(1) requirements; six (6) of the proposed rule rescissions are subject to the section 193 requirements. One (1) of the seven (7) proposed rule revisions is subject to section 110(1) requirements, one (1) is a Title V Part 70 revision, one (1) is a 111(d) plan revision and

the remaining four (4) proposed rule revisions are administrative in nature only.

COMMENT #2: The EPA suggests a demonstration that quantifies any emissions increase or potential increase by rescinding the rule(s), and a discussion on the impact on air quality. This demonstration could be done by comparing the source inventory at the time the rule was promulgated to the source inventory now, and demonstrating the overall impact on emissions. In addition, the department could include a discussion of the monitored air quality when the rule was promulgated/incorporated into the SIP and monitored air quality trends that demonstrate an improvement in air quality and how the rescission of the rule might impact those trends.

COMMENT #3: The EPA suggests a discussion of the rule's purpose; specifically, whether the rule was promulgated to meet nonattainment area requirements, and if so, which specific NAAQS. In addition, the department could describe how the rule no longer serves to meet that purpose or how the rule has been superseded by another permanent and enforceable mechanism.

COMMENT #4: The EPA suggests a discussion of whether the rule was used to support other actions and whether the removal of the rule would impact those obligations such as an attainment demonstration, a request for a determination to attainment, a redesignation request and maintenance plan, or other actions such as Regional Haze or Interstate Transport.

COMMENT #5: The EPA suggests that where the department may be anticipating other federal programs, such as Maximum Achievable Control Technology (MACT) and National Emissions Standards for Hazardous Air Pollutants, as acting as a backstop to removal of its Reasonably Available Control Technology (RACT) rules, a comprehensive discussion of how those programs equal RACT. For example, there may be volatile organic compound (VOC) sources regulated by these programs that are well-controlled through add-on controls, or even through substitution of non-hazardous air pollutant material for VOC hazardous air pollutant materials, however, these programs only cover air toxics and not all VOC emissions that RACT would capture and control are air toxics.

RESPONSE: The rescission of this rule is consistent with Executive Order 17-03 requiring a review of every regulation to affirm that the regulation is essential to the health, safety, or welfare of Missouri residents. The review of this rule indicated that no sources are subject to the rule, that the rule does not reduce any air pollutant, and therefore is not essential. Previously subject sources either have gone out of business or the source is no longer subject to the rule. In some cases, the source has been out of business or not subject to the rule for years. While a rule may have applied to a source to reduce or limit air pollutants in the past, the source is no longer producing the regulated emissions and the rule is no longer needed or relied upon for emission reductions going forward. To address EPA's concern about limiting VOC emissions from a new source, the department reiterates that RACT rules were intended to apply to existing major sources in nonattainment areas present at the time of the rule's promulgation. Any new source would not be subject to a RACT rule and instead would be subject to current applicable state or federal rules. Those state and federal rules would serve as the backstop limiting VOC emissions. These rules are not relied upon for any SIP purposes.

Due to similar concerns expressed in the following seven (7) comments, one (1) response that addresses these concerns is at the end of these seven (7) comments.

COMMENT #6: The Rulemaking Report indicates that "this rule applied Reasonably Available Control Technology to major sources of volatile organic compounds emissions from the use of large quantities of solvent cleaners in the Kansas City nonattainment area. Generally, RACT rules apply to those sources that were subject because they existed at the time the RACT rule became effective and are still currently operating." However, the rule language indicates that it applies to any person who performs or allows the performance

of any cleaning operation involving the use of a VOC solvent or solvent solution unless cleaning solvent VOCs are emitted at less than five hundred (500) pounds per day. Because the rule, as written, does not specifically say if it would or would not apply to a new or modified solvent cleanup operation with potential emissions of greater than five hundred (500) pounds of VOCs per day upon start-up, and the rule could read to imply that it would, the department should provide clarification of the rule's applicability and demonstrate that the SIP revision would not interfere with attainment of the NAAQS.

COMMENT #7: A potential way for the department to demonstrate that the SIP revision would not interfere with attainment of the NAAQS might be to provide an explanation of how its SIP-approved Prevention of Significant Deterioration (PSD) program would ensure that the start-up of a new source or modification of an existing source would be controlled in an equivalent manner as would be required by the rescinded rule.

COMMENT #8: If in the event the start-up of a new source or modification to an existing source would not be applicable under PSD but would otherwise be an applicable source under the rescinded rule, the department should provide a demonstration of the potential emissions from such sources and make a determination about the source's potential impact on air quality.

COMMENT #9: The department could supplement this demonstration by providing information on why it believes no new or modified sources will start-up (i.e., Are solvent cleanup operations no longer performed, or do those operations always meet one (1) of the exceptions to the rescinded rule? Do solvent clean-up operations no longer use VOCs?).

COMMENT #10: The department could demonstrate that the associated limits on hazardous air pollutants also limit VOCs. The department may want to evaluate if the MACT for Halogenated Solvent Cleaning could address the proposed rescission of this RACT rule, although many of the halogenated solvents are specifically not VOCs (i.e., the MACT regulates six (6) solvents specifically and only two (2) of those are VOCs).

COMMENT #11: The Rulemaking Report states that the only applicable source at the time of the rule's effective date was Ford Claycomo and that this source is now exempt, making the rule obsolete. However, the fiscal notes published in the October 2, 2000, and April 1, 2001, *Missouri Register* do not provide this information. The EPA recommends, for clarity to the public, that the department add an explanation in the Purpose section of the rescission how this rule only applied to the Ford Claycomo facility.

COMMENT #12: The Rulemaking Report indicates that the rule is obsolete because the Ford Claycomo facility is now exempt. However, the report does not indicate to the public why the facility is exempt. The EPA recommends that the department provide additional explanation on how it was determined that the source is now exempt from the rule.

RESPONSE: The rescission of this RACT rule is consistent with Executive Order 17-03 requiring a review of every state regulation to affirm that the regulation is necessary. The review of this rule indicated there are no sources subject to the rule, making the rule obsolete. In this case, the source is exempt from the rule according to their current operating permit because the facility uses solvents for nonmanufacturing area cleaning. This rescission will not have a negative effect on air quality since the rule does not function to reduce emissions (no sources regulated) or achieve attainment or maintenance of the NAAQS (SIP requirements met). To address EPA's concern about limiting VOC emissions from a new source, the department reiterates that RACT rules were intended to apply to existing major sources in nonattainment areas present at the time of the rule's promulgation. Any new sources or major modifications of existing sources would not be subject to this RACT rule and instead would be subject to New Source Review permitting and current applicable state or federal rules. Those state and federal rules would serve as the backstop limiting VOC emissions. The rule is not relied upon for any SIP purposes since there are no affected sources.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 2—Air Quality Standards and Air Pollution
Control Rules Specific to the Kansas City Metropolitan Area

ORDER OF RULEMAKING

By the authority vested in the Missouri Air Conservation Commission under section 643.050, RSMo 2016, the commission amends a rule as follows:

10 CSR 10-2.320 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on May 15, 2018 (43 MoReg 1016–1017). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Air Pollution Control Program received ten (10) comments from one (1) source, the U.S. Environmental Protection Agency (EPA).

Due to similar concerns expressed in the following five (5) comments, one (1) response that addresses these concerns is at the end of these five (5) comments.

COMMENT #1: The EPA provided a general comment for all the rules that the department has the responsibility to ensure that the State Implementation Plan (SIP) revision submitted to EPA meets the requirements of sections 110(1) and 193 of the Clean Air Act (CAA).

Section 110(1): Generally, section 110(1) provides that EPA cannot approve a SIP revision if the revision interferes with any applicable requirement concerning attainment and reasonable further progress or any other requirement of the CAA. This section applies to any area and to any National Ambient Air Quality Standard (NAAQS) pollutant and/or precursor. Thus, any SIP rule is subject to this section.

Section 193: Section 193 prohibits modification of a SIP in effect before 1990 unless that modification would ensure equivalent or greater emissions reductions, i.e., “anti-backsliding.” Section 193 applies only to nonattainment areas and is specific to the nonattainment pollutant. The applicability of section 193 is specific to nonattainment “criteria” pollutants. The ozone implementation rule (codified at 40 CFR 51.905(a)(4)), describes how section 193 applies to Kansas City - an attainment area for the eight (8)-hour standard and maintenance area for the one (1)-hour standard.

Each of the eleven (11) proposed rule rescissions are subject to section 110(1) requirements; six (6) of the proposed rule rescissions are subject to the section 193 requirements. One (1) of the seven (7) proposed rule revisions is subject to section 110(1) requirements, one (1) is a Title V Part 70 revision, one (1) is a 111(d) plan revision and the remaining four (4) proposed rule revisions are administrative in nature only.

COMMENT #2: The EPA suggests a demonstration that quantifies any emissions increase or potential increase by rescinding the rule(s), and a discussion on the impact on air quality. This demonstration could be done by comparing the source inventory at the time the rule was promulgated to the source inventory now, and demonstrating the overall impact on emissions. In addition, the department could include a discussion of the monitored air quality when the rule was promulgated/incorporated into the SIP and monitored air quality trends that demonstrate an improvement in air quality and how the rescission of the rule might impact those trends.

COMMENT #3: The EPA suggests a discussion of the rule's purpose; specifically, whether the rule was promulgated to meet nonattainment area requirements, and if so, which specific NAAQS. In

addition, the department could describe how the rule no longer serves to meet that purpose or how the rule has been superseded by another permanent and enforceable mechanism.

COMMENT #4: The EPA suggests a discussion of whether the rule was used to support other actions and whether the removal of the rule would impact those obligations such as an attainment demonstration, a request for a determination to attainment, a redesignation request and maintenance plan, or other actions such as Regional Haze or Interstate Transport.

COMMENT #5: The EPA suggests that where the department may be anticipating other federal programs, such as Maximum Achievable Control Technology and National Emissions Standards for Hazardous Air Pollutants, as acting as a backstop to removal of its Reasonably Available Control Technology (RACT) rules, a comprehensive discussion of how those programs equal RACT. For example, there may be volatile organic compound (VOC) sources regulated by these programs that are well-controlled through add-on controls, or even through substitution of non-hazardous air pollutant material for VOC hazardous air pollutant materials, however, these programs only cover air toxics and not all VOC emissions that RACT would capture and control are air toxics.

RESPONSE: The amendment of the rule is consistent with Executive Order 17-03 requiring a review of every regulation to affirm that the regulation is essential to the health, safety, or welfare of Missouri residents. Emissions will not increase with the proposed rule amendment and the revision will meet CAA sections 110(1) and 193 requirements. There is no negative impact on air quality. The department is not anticipating the use of other federal programs as a backstop because the department is not rescinding this rule. No changes were made to the rule text as a result of these comments.

COMMENT #6: The EPA recommends that the department consider revising section (3) General Provisions. Section (3) says “source operations in installations affected by this regulation that are venting emissions to VOC emission control devices [...] shall be required to continue venting emissions to these control devices and these emissions shall be controlled to the extent required in section (4) of this regulation.” However, the proposed revisions of the rule add the emission limitations under a new subsection (3)(A) and change section (4) to Record Keeping and Reporting. Therefore, the department should revise the section (4) reference to subsection (3)(A).

RESPONSE AND EXPLANATION OF CHANGE: The reorganization of the rule did change the location of the emission limits in the rule from its previous section (4). The limits are now found in section (3) and the rule text has been corrected as a result of this comment.

COMMENT #7: The EPA recommends that the department consider revising its addition of subsection (3)(B) Compliance Method and instead add the information provided in the new subsection (3)(B) to section (5) Test Methods that currently says “(Not Applicable)”. The rule requires testing methods but they are in the new subsection (3)(B). This change would also provide consistency with the formatting of other department Air Conservation Commission Rules.

RESPONSE AND EXPLANATION OF CHANGE: As a result of this comment, the compliance methods proposed in subsection (3)(B) are being moved to section (5).

COMMENT #8: The EPA recommends that the department consider removing the word “Reporting” from the title of section (4). The word “Reporting” is being added to the title of new section (4) Record Keeping and Reporting even though no reporting is required by rule. This could be confusing to the public and the regulated community.

RESPONSE: The use of Reporting and Recordkeeping as a section heading is consistent with the standard rule organization format that the department uses for its air pollution rules. The heading in this format just indicates that reporting and recordkeeping requirements, if applicable, are located in this section of the rule. No changes were made to the rule text as a result of this comment.

COMMENT #9: There is a reference at paragraph (3)(B)l. to 10 CSR 10-6.030(22) however, section (22) does not exist in the state's 10 CSR 10-6.030 Sampling Methods. The EPA understands that the department is in the process of revising 10 CSR 10-6.030 Sampling Methods and that those potential rule changes are being made available for public comment concurrent with this rule. As such, EPA would not act on this submission until 10 CSR 10-6.030 was also submitted to EPA.

RESPONSE: The department is currently in the process of amending rule 10 CSR 10-6.030 Sampling Methods for Air Pollution Sources and plans to submit this rule for inclusion into the SIP before, or concurrently with the submittal to EPA of amendments to 10 CSR 10-2.320. No changes were made to the rule text as a result of this comment.

COMMENT #10: The EPA encourages the department to consider adding "40 CFR 60, Appendix A" instead of adding a reference to 10 CSR 10-6.030(22) in subsection (3)(B) of this rule. The section already specifies which test method to use (Method 25) and the draft rule text language for the potential revisions to 10 CSR 10-6.030 adds section (22), which incorporates 40 CFR 60, in whole, by reference. It may be unnecessary to divert the public to another state regulation that incorporates a federal regulation by reference and provides no additional clarity than what is already specified in the subsection (3)(B).

RESPONSE: The department appreciates this comment and for all air rules found in 10 CSR 10-Chapters 1–6, where stack testing methods or guidance documents are mentioned, a reference to rule 10 CSR 10-6.030 reduces the length of federal content incorporated by reference into these rules. No changes were made to the rule text as a result of this comment.

10 CSR 10-2.320 Control of Emissions From Production of Pesticides and Herbicides

(3) General Provisions. All source operations in installations affected by this regulation that are venting emissions to VOC emission control devices as of November 23, 1987 shall be required to continue venting emissions to these control devices and these emissions shall be controlled to the extent required in this section. Any pesticide or herbicide manufacturing installation VOC emissions control devices subject to this regulation must achieve an instantaneous VOC destruction or removal efficiency greater than or equal to ninety-nine percent (99%).

(5) Test Methods.

(A) VOC compliance is to be determined by test method 25 as specified in 10 CSR 10-6.030(22).

(B) For thermal oxidizers, compliance is to be determined by the combustion chamber temperature and residence time after adequate test results, as determined by the director, are provided by the owners or operators. These test results are subject to periodic confirmation at the discretion of the director. Combustion chamber gas temperature is to be monitored with an accuracy of the greater of $\pm 0.75\%$ of the temperature being measured expressed in degrees Celsius or 2.5 degrees Celsius.

Title 10—DEPARTMENT OF NATURAL RESOURCES Division 10—Air Conservation Commission Chapter 2—Air Quality Standards and Air Pollution Control Rules Specific to the Kansas City Metropolitan Area

ORDER OF RULEMAKING

By the authority vested in the Missouri Air Conservation Commission under section 643.050, RSMo 2016, the commission

amends a rule as follows:

10 CSR 10-2.340 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on May 15, 2018 (43 MoReg 1017–1018). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Air Pollution Control Program received ten (10) comments on this rulemaking from the U.S. Environmental Protection Agency (EPA) and one (1) comment from department staff.

Due to similar concerns expressed in the following five (5) comments, one (1) response that addresses these concerns is at the end of these five (5) comments.

COMMENT #1: The EPA provided a general comment for all the rules that the department has the responsibility to ensure that the State Implementation Plan (SIP) revision submitted to EPA meets the requirements of sections 110(1) and 193 of the Clean Air Act (CAA).

Section 110(1): Generally, section 110(1) provides that EPA cannot approve a SIP revision if the revision interferes with any applicable requirement concerning attainment and reasonable further progress or any other requirement of the CAA. This section applies to any area and to any National Ambient Air Quality Standard (NAAQS) pollutant and/or precursor. Thus, any SIP rule is subject to this section.

Section 193: Section 193 prohibits modification of a SIP in effect before 1990 unless that modification would ensure equivalent or greater emissions reductions, i.e., "anti-backsliding." Section 193 applies only to nonattainment areas and is specific to the nonattainment pollutant. The applicability of section 193 is specific to nonattainment "criteria" pollutants. The ozone implementation rule (codified at 40 CFR 51.905(a)(4)), describes how section 193 applies to Kansas City - an attainment area for the eight (8)-hour standard and maintenance area for the one (1)-hour standard.

Each of the eleven (11) proposed rule rescissions are subject to section 110(1) requirements; six (6) of the proposed rule rescissions are subject to the section 193 requirements. One (1) of the seven (7) proposed rule revisions is subject to section 110(1) requirements, one (1) is a Title V Part 70 revision, one (1) is a 111(d) plan revision and the remaining four (4) proposed rule revisions are administrative in nature only.

COMMENT #2: The EPA suggests a demonstration that quantifies any emissions increase or potential increase by rescinding the rule(s), and a discussion on the impact on air quality. This demonstration could be done by comparing the source inventory at the time the rule was promulgated to the source inventory now, and demonstrating the overall impact on emissions. In addition, the department could include a discussion of the monitored air quality when the rule was promulgated/incorporated into the SIP and monitored air quality trends that demonstrate an improvement in air quality and how the rescission of the rule might impact those trends.

COMMENT #3: The EPA suggests a discussion of the rule's purpose; specifically, whether the rule was promulgated to meet nonattainment area requirements, and if so, which specific NAAQS. In addition, the department could describe how the rule no longer serves to meet that purpose or how the rule has been superseded by another permanent and enforceable mechanism.

COMMENT #4: The EPA suggests a discussion of whether the rule was used to support other actions and whether the removal of the rule would impact those obligations such as an attainment demonstration, a request for a determination to attainment, a redesignation request and maintenance plan, or other actions such as Regional Haze or Interstate Transport.

COMMENT #5: The EPA suggests that where the department may be anticipating other federal programs, such as Maximum Achievable Control Technology and National Emissions Standards for Hazardous Air Pollutants, as acting as a backstop to removal of its Reasonably Available Control Technology (RACT) rules, a comprehensive discussion of how those programs equal RACT. For example, there may be volatile organic compound (VOC) sources regulated by these programs that are well-controlled through add-on controls, or even through substitution of non-hazardous air pollutant material for VOC hazardous air pollutant materials, however, these programs only cover air toxics and not all VOC emissions that RACT would capture and control are air toxics.

RESPONSE: The amendment of the rule is consistent with Executive Order 17-03 requiring a review of every regulation to affirm that the regulation is essential to the health, safety, or welfare of Missouri residents. Emissions will not increase with the proposed rule amendment and the revision will meet CAA sections 110(l) and 193 requirements. There is no negative impact on air quality. The department is not anticipating the use of other federal programs as a backstop because the department is not rescinding this rule. No changes were made to the rule text as a result of these comments.

COMMENT #6: The department is proposing to revise the title of the rule to include the words “and letterpress.” The EPA recommends that the department considering adding the words “and letterpress” to the Purpose section of the rule which currently says, “This regulation restricts volatile organic compound emissions from lithographic printing [facilities] operations” so that the title and purpose match to reduce confusion. Because the department is adding the word “letterpress” to the title of the rule, EPA recommends that the department consider adding the word “letterpress” to sections (1) Applicability and (3) General Provisions of the rule.

RESPONSE AND EXPLANATION OF CHANGE: As a result of this comment, the words “and letterpress” will be added to the purpose; subsections (1)(B), (3)(A), (3)(B), and (3)(C); and paragraph (1)(C)2.

COMMENT #7: The EPA recommends that the department consider adding a definition at section (2) of the rule for “letterpress printing”. If the department decides to add the definition to the rule, there is an existing definition of “letterpress printing” at paragraph (2)(L)7. of 10 CSR 10-6.020 Definitions and Common Reference Tables that could be used to provide consistency between the department Air Conservation Commission Rules. A definition for “lithographic printing” is already provided at section (2) of 10 CSR 10-2.340.

RESPONSE AND EXPLANATION OF CHANGE: As a result of this comment, the definition of “letterpress printing” will be added to section (2) and this section will be renumbered accordingly.

COMMENT #8: In paragraph (3)(B)2. the department is proposing to remove the following language: “The cloths, when properly cleaned or disposed of, are processed in a way that as much of the solvent, as practicable, is recovered for further use or destroyed. Cleaning and disposal methods shall be approved by the director.” The department will need to submit a demonstration showing how the removal of the requirement that “as much of the solvent is recovered for further use or destroyed” from the department’s SIP, meets the requirements of CAA sections 110(1) and 193, also known as the “anti-backsliding” provisions.

RESPONSE AND EXPLANATION OF CHANGE: Removing this language was an attempt to provide consistency with the St. Louis area rule 10 CSR 10-5.442, paragraph (3)(B)3. where it is not included. However, the department has determined that this phrase is necessary in 10 CSR 10-2.340 for historical purposes. As a result of this comment, this language will be retained.

COMMENT #9: There is a reference at subsection (5)(A) to 10 CSR 10-6.030(22) however, section (22) does not exist in the state’s 10 CSR 10-6.030 Sampling Methods. The EPA understands that the

department is in the process of revising 10 CSR 10-6.030 Sampling Methods and that those potential rule changes are being made available for public comment concurrent with this rule. As such, EPA would not act on this submission until 10 CSR 10-6.030 was also submitted to EPA.

RESPONSE: The department is currently in the process of amending rule 10 CSR 10-6.030 Sampling Methods for Air Pollution Sources and plans to submit this rule for inclusion into the SIP before, or concurrently with the submittal to EPA of amendments to 10 CSR 10-2.340. As a result of this comment, no changes have been made to the rule text.

COMMENT #10: The EPA encourages the department to assess the need for adding a reference to 10 CSR 10-6.030(22) in subsection (5)(A) of this rule because the section already specifies which test method to use (Method 25 or 25A respectively) and where the methods can be found (40 CFR 60, Appendix A). The draft rule text language for the potential revisions to 10 CSR 10-6.030 adds section (22), which incorporates 40 CFR 60, in whole, by reference. It may be unnecessary to divert the public to another state regulation that incorporates a federal regulation by reference and provides no additional clarity than what is already specified in subsection (5)(A).

RESPONSE: The department appreciates this comment and for all air rules found in 10 CSR 10-Chapters 1–6, where stack testing methods or guidance documents are mentioned more than once, a reference to rule 10 CSR 10-6.030 reduces the length of federal content incorporated by reference into these rules. No changes were made to the rule text as a result of this comment.

COMMENT #11: Department staff commented that all the subsections in section (2) should have periods at the end of them for consistency in rule formats.

RESPONSE AND EXPLANATION OF CHANGE: As a result of this comment, the periods have been added to the end of all the subsections in section (2).

10 CSR 10-2.340 Control of Emissions From Lithographic and Letterpress Printing Operations

PURPOSE: *This regulation restricts volatile organic compound emissions from lithographic and letterpress printing operations.*

(1) Applicability.

(B) This regulation shall apply to installations that have calculated actual volatile organic compound (VOC) emissions for a known number of crewed hours, increased by the amount by weight of VOCs whose emission into the atmosphere is prevented by the use of air pollution control devices and extrapolated to eight thousand seven hundred sixty (8,760) hours per year equal to or greater than one hundred (100) tons per year from offset lithographic and letterpress printing presses after December 9, 1991. The following factors shall be taken into consideration unless an alternative method is approved by the director:

1. Assume fifty percent (50%) of the solvent used for cleanup is retained in the rag(s) when the used solvent-laden rag(s) are cleaned or disposed of. The installation must demonstrate to the director that the solvents are not evaporated into the air when the waste rags are properly cleaned and disposed of;

2. Assume forty percent (40%) of the heatset ink oils stay in the paper web;

3. Assume no VOCs are emitted from the inks used in sheet-fed presses and nonheatset web presses; and

4. Assume that fifty percent (50%) of the alcohol from the fountain solution is emitted from the dryer.

(C) This regulation does not apply to—

1. Printing on fabric, metal, or plastic;

2. Sheet-fed lithographic and letterpress presses with cylinder widths of twenty-six inches (26") or less; or

3. Web lithographic and letterpress presses with cylinder widths

of eighteen inches (18") or less.

(2) Definitions.

(A) Alcohol—Refers to isopropanol, isopropyl alcohol, normal propyl alcohol, or ethanol.

(B) Coating—A protective, decorative, or functional material applied in a thin layer to a surface. Such materials include, but are not limited to, paints, topcoats, varnishes, sealers, stains, washcoats, basecoats, inks, and temporary protective coatings.

(C) Fountain solution—The solution which is applied to the image plate to maintain the hydrophilic properties of the nonimage areas. It is primarily water containing an etchant, gum arabic, and a dampening aid (commonly containing alcohol and alcohol substitutes).

(D) Heatset—A class of web-offset lithographic and letterpress printing in which the setting of the printing inks requires a heated dryer to evaporate the ink oils. The setting or curing of inks using only radiation (e.g., infrared, ultraviolet light, or electron beam) is not heatset and is classified as nonheatset.

(E) Letterpress printing—A printing process in which the image area is raised relative to the nonimage area, and the ink is transferred to the substrate directly from the image surface.

(F) Lithographic printing—A planographic printing process where the image and nonimage areas are chemically differentiated; the image area is oil receptive and the nonimage area is water receptive. This method differs from other printing methods, where the image is typically printed from a raised or recessed surface. Offset lithographic printing is the only common type of lithographic printing used for commercial printing.

(G) Offset lithographic printing—A printing process that transfers the ink film from the lithographic plate to an intermediary surface (rubber-covered blanket cylinder), which, in turn, transfers the ink film to the substrate.

(H) Sheet-fed—A printing press where individual sheets of substrate are fed into the press sequentially.

(I) Web—A printing process where a continuous roll of substrate is fed into the press.

(J) Definitions of certain terms in this rule, other than those specified in this rule section may be found in 10 CSR 10-6.020.

(3) General Provisions.

(A) No owner or operator shall use or permit the use of any offset lithographic and letterpress printing press unless—

1. The fountain solution contains ten percent (10%) or less by weight of alcohol;

2. The fountain solution is refrigerated to a temperature of fifty-five degrees Fahrenheit (55°F) or less for alcohol-based solutions;

3. The fountain solution temperature at the mixing tank for alcohol-based solutions is monitored during each shift; and

4. The fountain solution mixing tanks are covered for alcohol-based solutions.

(B) No owner or operator shall use or permit the use of any offset lithographic and letterpress printing press that uses cleanup solvents containing VOCs unless—

1. The cleanup solvents are kept in tightly covered tanks or containers during transport and storage;

2. The cleaning cloths used with the cleanup solvents are placed in tightly closed containers when not in use and while awaiting off-site transportation. The cleaning cloths should be properly cleaned and disposed of. The cloths, when properly cleaned or disposed of, are processed in a way that as much of the solvent, as practicable, is recovered for further use or destroyed. Cleaning and disposal methods shall be approved by the director; and

3. An owner or operator may use an alternate method for reducing cleanup solvent VOC emissions, including the use of low VOC cleanup solvents, if the owner or operator shows the emission reduction is equal to or greater than those in paragraphs (3)(B)1. and 2. This alternate method is approved by the director.

(C) No owner or operator shall use or permit the use of any heatset web-offset lithographic and letterpress printing press that uses a

dryer that has ever had an actual emission rate of ten (10) tons per year or more VOCs after December 9, 1991, unless one hundred percent (100%) of the dryer exhaust is ducted to a control device that achieves eighty-five percent (85%) by weight or greater control efficiency.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 2—Air Quality Standards and Air Pollution
Control Rules Specific to the Kansas City Metropolitan Area

ORDER OF RULEMAKING

By the authority vested in the Missouri Air Conservation Commission under section 643.050, RSMo 2016, the commission rescinds a rule as follows:

10 CSR 10-2.390 Kansas City Area Transportation Conformity Requirements is rescinded.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on May 15, 2018 (43 MoReg 1018-1019). No changes were made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Air Pollution Control Program received five (5) comments on this rulemaking from the U.S. Environmental Protection Agency (EPA).

Due to similar concerns expressed in the following five (5) comments, one (1) response that addresses these concerns is at the end of these five (5) comments.

COMMENT #1: The EPA provided a general comment for all the rules that the department has the responsibility to ensure that the State Implementation Plan (SIP) revision submitted to EPA meets the requirements of sections 110(1) and 193 of the Clean Air Act (CAA).

Section 110(1): Generally, section 110(1) provides that EPA cannot approve a SIP revision if the revision interferes with any applicable requirement concerning attainment and reasonable further progress or any other requirement of the CAA. This section applies to any area and to any National Ambient Air Quality Standard (NAAQS) pollutant and/or precursor. Thus, any SIP rule is subject to this section.

Section 193: Section 193 prohibits modification of a SIP in effect before 1990 unless that modification would ensure equivalent or greater emissions reductions, i.e., "anti-backsliding." Section 193 applies only to nonattainment areas and is specific to the nonattainment pollutant. The applicability of section 193 is specific to nonattainment "criteria" pollutants. The ozone implementation rule (codified at 40 CFR 51.905(a)(4)), describes how section 193 applies to Kansas City - an attainment area for the eight (8)-hour standard and maintenance area for the one (1)-hour standard.

Each of the eleven (11) proposed rule rescissions are subject to section 110(1) requirements; six (6) of the proposed rule rescissions are subject to the section 193 requirements. One (1) of the seven (7) proposed rule revisions is subject to section 110(1) requirements, one (1) is a Title V Part 70 revision, one (1) is a 111(d) plan revision and the remaining four (4) proposed rule revisions are administrative in nature only.

COMMENT #2: The EPA suggests a demonstration that quantifies any emissions increase or potential increase by rescinding the rule(s), and a discussion on the impact on air quality. This demonstration could be done by comparing the source inventory at the time the rule

was promulgated to the source inventory now, and demonstrating the overall impact on emissions. In addition, the department could include a discussion of the monitored air quality when the rule was promulgated/incorporated into the SIP and monitored air quality trends that demonstrate an improvement in air quality and how the rescission of the rule might impact those trends.

COMMENT #3: The EPA suggests a discussion of the rule's purpose; specifically, whether the rule was promulgated to meet nonattainment area requirements, and if so, which specific NAAQS. In addition, the department could describe how the rule no longer serves to meet that purpose or how the rule has been superseded by another permanent and enforceable mechanism.

COMMENT #4: The EPA suggests a discussion of whether the rule was used to support other actions and whether the removal of the rule would impact those obligations such as an attainment demonstration, a request for a determination to attainment, a redesignation request and maintenance plan, or other actions such as Regional Haze or Interstate Transport.

COMMENT #5: The EPA suggests where the department may be anticipating other federal programs, such as Maximum Achievable Control Technology and National Emissions Standards for Hazardous Air Pollutants, as acting as a backstop to removal of its Reasonably Available Control Technology (RACT) rules, a comprehensive discussion of how those programs equal RACT. For example, there may be volatile organic compound (VOC) sources regulated by these programs that are well controlled through add-on controls, or even through substitution of non-hazardous air pollutant material for VOC hazardous air pollutant materials, however, these programs only cover air toxics and not all VOC emissions that RACT would capture and control are air toxics.

RESPONSE: The rescission of this rule is consistent with Executive Order 17-03 requiring a review of every regulation to affirm that the regulation is essential to the health, safety, or welfare of Missouri residents. The review of this rule indicated that no sources are subject to the rule, that the rule does not reduce any air pollutant, and therefore is not essential. Previously subject sources either have gone out of business or the source is no longer subject to the rule. In some cases, the source has been out of business or not subject to the rule for years. While a rule may have applied to a source to reduce or limit air pollutants in the past, the source is no longer producing the regulated emissions and the rule is no longer needed or relied upon for emission reductions going forward. To address EPA's concern about limiting VOC emissions from a new source, the department reiterates that RACT rules were intended to apply to existing major sources in nonattainment areas present at the time of the rule's promulgation. Any new source would not be subject to a RACT rule and instead would be subject to current applicable state or federal rules. Those state and federal rules would serve as the backstop limiting VOC emissions. These rules are not relied upon for any SIP purposes.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 5—Air Quality Standards and Air Pollution
Control Rules Specific to the St. Louis Metropolitan Area

ORDER OF RULEMAKING

By the authority vested in the Missouri Air Conservation Commission under section 643.050, RSMo 2016, the commission rescinds a rule as follows:

10 CSR 10-5.360 Control of Emissions From Polyethylene Bag Sealing Operations is rescinded.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on May 15, 2018 (43 MoReg 1019). No changes were made in the proposed rescission, so it is not

reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Air Pollution Control Program received eleven (11) comments from one (1) source, the U.S. Environmental Protection Agency (EPA).

Due to similar concerns expressed in the following five (5) comments, one (1) response that addresses these concerns is at the end of these five (5) comments.

COMMENT #1: The EPA provided a general comment for all the rules that the department has the responsibility to ensure that the State Implementation Plan (SIP) revision submitted to EPA meets the requirements of sections 110(1) and 193 of the Clean Air Act (CAA).

Section 110(1): Generally, section 110(1) provides that EPA cannot approve a SIP revision if the revision interferes with any applicable requirement concerning attainment and reasonable further progress (RFP) or any other requirement of the CAA. This section applies to any area and to any National Ambient Air Quality Standard (NAAQS) pollutant and/or precursor. Thus, any SIP rule is subject to this section.

Section 193: Section 193 prohibits modification of a SIP in effect before 1990 unless that modification would ensure equivalent or greater emissions reductions, i.e., "anti-backsliding." Section 193 applies only to nonattainment areas and is specific to the nonattainment pollutant. The applicability of section 193 is specific to nonattainment "criteria" pollutants. The ozone implementation rule (codified at 40 CFR 51.905(a)(4)), describes how section 193 applies to Kansas City - an attainment area for the eight (8)-hour standard and maintenance area for the one (1)-hour standard.

Each of the eleven (11) proposed rule rescissions are subject to section 110(1) requirements; six (6) of the proposed rule rescissions are subject to the section 193 requirements. One (1) of the seven (7) proposed rule revisions is subject to section 110(1) requirements, one (1) is a Title V Part 70 revision, one (1) is a 111(d) plan revision and the remaining four (4) proposed rule revisions are administrative in nature only.

COMMENT #2: The EPA suggests a demonstration that quantifies any emissions increase or potential increase by rescinding the rule(s), and a discussion on the impact on air quality. This demonstration could be done by comparing the source inventory at the time the rule was promulgated to the source inventory now, and demonstrating the overall impact on emissions. In addition, the department could include a discussion of the monitored air quality when the rule was promulgated/incorporated into the SIP and monitored air quality trends that demonstrate an improvement in air quality and how the rescission of the rule might impact those trends.

COMMENT #3: The EPA suggests a discussion of the rule's purpose; specifically, whether the rule was promulgated to meet nonattainment area requirements, and if so, which specific NAAQS. In addition, the department could describe how the rule no longer serves to meet that purpose or how the rule has been superseded by another permanent and enforceable mechanism.

COMMENT #4: The EPA suggests a discussion of whether the rule was used to support other actions and whether the removal of the rule would impact those obligations such as an attainment demonstration, a request for a determination to attainment, a redesignation request and maintenance plan, or other actions such as Regional Haze or Interstate Transport.

COMMENT #5: The EPA suggests that where the department may be anticipating other federal programs, such as Maximum Achievable Control Technology (MACT) and National Emissions Standards for Hazardous Air Pollutants, as acting as a backstop to removal of its Reasonably Available Control Technology (RACT) rules, a comprehensive discussion of how those programs equal RACT. For example, there may be volatile organic compound (VOC) sources regulated by these programs that are well-controlled through add-on controls, or

even through substitution of non-hazardous air pollutant material for VOC hazardous air pollutant materials, however, these programs only cover air toxics and not all VOC emissions that RACT would capture and control are air toxics.

RESPONSE: The rescission of this rule is consistent with Executive Order 17-03 requiring a review of every regulation to affirm that the regulation is essential to the health, safety, or welfare of Missouri residents. The review of this rule indicated that no sources are subject to the rule, that the rule does not reduce any air pollutant, and therefore is not essential. Previously subject sources either have gone out of business or the source is no longer subject to the rule. In some cases, the source has been out of business or not subject to the rule for years. While a rule may have applied to a source to reduce or limit air pollutants in the past, the source is no longer producing the regulated emissions and the rule is no longer needed or relied upon for emission reductions going forward. To address EPA's concern about limiting VOC emissions from a new source, the department reiterates that RACT rules were intended to apply to existing major sources in nonattainment areas present at the time of the rule's promulgation. Any new source would not be subject to a RACT rule and instead would be subject to current applicable state or federal rules. Those state and federal rules would serve as the backstop limiting VOC emissions. These rules are not relied upon for any SIP purposes.

Due to similar concerns expressed in the following six (6) comments, one (1) response that addresses these concerns is at the end of these six (6) comments.

COMMENT #6: The Rulemaking Report indicates that there were two (2) sources originally subject to the rule and that neither of those businesses are still in operation, making the rule obsolete. However, the rule language indicates that it applies throughout St. Louis City and Jefferson, St. Charles, Franklin, and St. Louis counties and that it applies to all installations that have the uncontrolled potential to emit more than one hundred (100) tons per year (tpy) or two hundred fifty (250) kilograms (kg) per day of VOCs from any polyethylene bag sealing operation. Because the rule, as written, does not specifically say if it would or would not apply to a new or modified polyethylene bag sealing operation with potential emissions of greater than 100 tpy or 250 kg per day of VOCs upon start-up, and the rule could read to imply that it would, the department should provide clarification of the rule's applicability and demonstrate that the SIP revision would not interfere with attainment of the NAAQS.

COMMENT #7: A potential way for the department to demonstrate that the SIP revision would not interfere with attainment of the NAAQS might be provide explanation of how its SIP-approved Prevention of Significant Deterioration (PSD) program would ensure that the start-up of a new source or modification of an existing source would be controlled in an equivalent manner as would be required by the rescinded rule.

COMMENT #8: If EPA's proposed rulemaking to redesignate the Missouri portion of the St. Louis-St. Charles-Farmington, MO-IL 2008 ozone area to attainment is finalized as proposed, Nonattainment New Source Review (NNSR) will no longer apply in Jefferson County and portions of Franklin County and new sources in those counties will then have a potential to emit of up to two hundred forty-nine (249) tpy without being subject to PSD, MACT, or New Source Performance Standards. Because of the change in applicability of NNSR, the department will need to ensure that the department's SIP submission meets the requirements of sections 110(1) and 193 of the CAA, also known as the "antibacksliding" provisions. These sections relate to EPA's authority to approve a SIP revision that removes or modifies control measure(s) in the SIP only after the state has demonstrated that such a removal or modification will not interfere with attainment of the NAAQS, RFP, or any other applicable requirement of the CAA.

COMMENT #9: If in the event the start-up of a new source or modification to an existing source would not be applicable under PSD but

would otherwise be an applicable source under the rescinded rule, the department should provide a demonstration of the potential emissions from such sources and make a determination about the source's potential impact on air quality.

COMMENT #10: The department could supplement this demonstration by providing information on why it believes no new or modified sources will start-up (i.e., Are polyethylene bags no longer sealed, or do those operations always meet one (1) of the exceptions to the rescinded rule? Do bag sealing operations no longer emit VOCs?).

COMMENT #11: Additionally, the department's Redesignation Request and Maintenance Plan for the St. Louis, Missouri 2008 Ozone Standard Nonattainment Area is unclear whether this rule is relied upon to attain and maintain the standard. As such, the SIP revision submission for rescinding this rule should discuss any potential impact of rescinding the rule on that plan.

RESPONSE: The rescission of this RACT rule is consistent with Executive Order 17-03 requiring a review of every state regulation to affirm that the regulation is necessary. The review of this rule indicated there are no sources subject to the rule, making the rule obsolete. This rescission will not have a negative effect on air quality since the rule does not function to reduce emissions (no sources regulated) or achieve attainment or maintenance of the NAAQS (SIP requirements met). To address EPA's concern about limiting VOC emissions from a new source, the department reiterates that RACT rules were intended to apply to existing major sources in nonattainment areas present at the time of the rule's promulgation. Any new sources or major modifications of existing sources would not be subject to this RACT rule and instead would be subject to New Source Review permitting and current applicable state or federal rules. Those state and federal rules would serve as the backstop limiting VOC emissions. This rule is not relied upon for any SIP purposes since there are no affected sources.

Title 10—DEPARTMENT OF NATURAL RESOURCES

Division 10—Air Conservation Commission

Chapter 5—Air Quality Standards and Air Pollution

Control Rules Specific to the St. Louis Metropolitan Area

ORDER OF RULEMAKING

By the authority vested in the Missouri Air Conservation Commission under section 643.050, RSMo 2016, the commission rescinds a rule as follows:

10 CSR 10-5.370 Control of Emissions From the Application of **Deadeners and Adhesives is rescinded.**

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on May 15, 2018 (43 MoReg 1019). No changes were made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Air Pollution Control Program received twelve (12) comments on this rulemaking from the U.S. Environmental Protection Agency (EPA).

Due to similar concerns expressed in the following five (5) comments, one (1) response that addresses these concerns is at the end of these five (5) comments.

COMMENT #1: The EPA provided a general comment for all the rules that the department has the responsibility to ensure that the State Implementation Plan (SIP) revision submitted to EPA meets the requirements of sections 110(1) and 193 of the Clean Air Act (CAA).

Section 110(1): Generally, section 110(1) provides that EPA cannot

approve a SIP revision if the revision interferes with any applicable requirement concerning attainment and reasonable further progress (RFP) or any other requirement of the CAA. This section applies to any area and to any National Ambient Air Quality Standard (NAAQS) pollutant and/or precursor. Thus, any SIP rule is subject to this section.

Section 193: Section 193 prohibits modification of a SIP in effect before 1990 unless that modification would ensure equivalent or greater emissions reductions, i.e., “anti-backsliding.” Section 193 applies only to nonattainment areas and is specific to the nonattainment pollutant. The applicability of section 193 is specific to nonattainment “criteria” pollutants. The ozone implementation rule (codified at 40 CFR 51.905(a)(4)), describes how section 193 applies to Kansas City - an attainment area for the eight (8)-hour standard and maintenance area for the one (1)-hour standard.

Each of the eleven (11) proposed rule rescissions are subject to section 110(1) requirements; six (6) of the proposed rule rescissions are subject to the section 193 requirements. One (1) of the seven (7) proposed rule revisions is subject to section 110(1) requirements, one (1) is a Title V Part 70 revision, one (1) is a 111(d) plan revision and the remaining four (4) proposed rule revisions are administrative in nature only.

COMMENT #2: The EPA suggests a demonstration that quantifies any emissions increase or potential increase by rescinding the rule(s), and a discussion on the impact on air quality. This demonstration could be done by comparing the source inventory at the time the rule was promulgated to the source inventory now, and demonstrating the overall impact on emissions. In addition, the department could include a discussion of the monitored air quality when the rule was promulgated/incorporated into the SIP and monitored air quality trends that demonstrate an improvement in air quality and how the rescission of the rule might impact those trends.

COMMENT #3: The EPA suggests a discussion of the rule’s purpose; specifically, whether the rule was promulgated to meet nonattainment area requirements, and if so, which specific NAAQS. In addition, the department could describe how the rule no longer serves to meet that purpose or how the rule has been superseded by another permanent and enforceable mechanism.

COMMENT #4: The EPA suggests a discussion of whether the rule was used to support other actions and whether the removal of the rule would impact those obligations such as an attainment demonstration, a request for a determination to attainment, a redesignation request and maintenance plan, or other actions such as Regional Haze or Interstate Transport.

COMMENT #5: The EPA suggests that where the department may be anticipating other federal programs, such as Maximum Achievable Control Technology (MACT) and National Emissions Standards for Hazardous Air Pollutants, as acting as a backstop to removal of its Reasonably Available Control Technology (RACT) rules, a comprehensive discussion of how those programs equal RACT. For example, there may be volatile organic compound (VOC) sources regulated by these programs that are well-controlled through add-on controls, or even through substitution of non-hazardous air pollutant material for VOC hazardous air pollutant (HAP) materials, however, these programs only cover air toxics and not all VOC emissions that RACT would capture and control are air toxics.

RESPONSE: The rescission of this rule is consistent with Executive Order 17-03 requiring a review of every regulation to affirm that the regulation is essential to the health, safety, or welfare of Missouri residents. The review of this rule indicated that no sources are subject to the rule, that the rule does not reduce any air pollutant, and therefore is not essential. Previously subject sources either have gone out of business or the source is no longer subject to the rule. In some cases, the source has been out of business or not subject to the rule for years. While a rule may have applied to a source to reduce or limit air pollutants in the past, the source is no longer producing the regulated emissions and the rule is no longer needed or relied upon for emission reductions going forward. To address EPA’s concern about limiting VOC emissions from a new source, the department

reiterates that RACT rules were intended to apply to existing major sources in nonattainment areas present at the time of the rule’s promulgation. Any new source would not be subject to a RACT rule and instead would be subject to current applicable state or federal rules. Those state and federal rules would serve as the backstop limiting VOC emissions. These rules are not relied upon for any SIP purposes.

Due to similar concerns expressed in the following seven (7) comments, one (1) response that addresses these concerns is at the end of these seven (7) comments.

COMMENT #6: The Rulemaking Report indicates that this “rule applied Reasonably Available Control Technology (RACT) to major sources of volatile organic compounds (VOC) emissions applying automotive underbody deadeners and adhesives in the St. Louis nonattainment area. Generally, RACT rules apply to those sources that were subject because they existed at the time the RACT rule became effective and are still currently operating.” The Rulemaking Report names the Chrysler Corporation and states that this source ceased operations in 2008 and that both the north and south facilities were razed in 2011. However, the rule language indicates that it applies throughout St. Louis City and Jefferson, St. Charles, Franklin, and St. Louis counties and that it applies to all installations that have the uncontrolled potential to emit (PTE) of more than one hundred (100) tons per year (tpy) or two hundred fifty (250) kilogram (kg) per day of VOC. Because the rule, as written, does not specifically say if it would or would not apply to a new or modified applicator of underbody deadener with potential emissions of VOCs greater than one hundred (100) tpy or two hundred fifty (250) kg per day upon start-up, and the rule could read to imply that it would, the department should provide clarification of the rule’s applicability and demonstrate that the SIP revision would not interfere with attainment of the NAAQS.

COMMENT #7: A potential way for the department to demonstrate that this SIP revision would not interfere with attainment of the NAAQS might be to provide an explanation of how its SIP-approved Prevention of Significant Deterioration (PSD) program would ensure that the start-up of a new source or modification of an existing source would be controlled in at least an equivalent manner as would be required by this rescinded rule.

COMMENT #8: If EPA’s proposed rulemaking to redesignate the Missouri portion of the St. Louis-St. Charles-Farmington, MO-IL 2008 Ozone area to attainment is finalized as proposed, Nonattainment New Source Review (NNSR) will no longer apply in Jefferson County and portions of Franklin County and new sources in those counties will then have a PTE of up to 249 tpy without being subject to PSD, MACT, or New Source Performance Standards. Because of the change in applicability of NNSR, the department will need to ensure that the department’s SIP submission meets the requirements of sections 110(1) and 193 of the CAA, also known as the “anti-backsliding” provisions. These sections relate to the EPA’s authority to approve a SIP revision that removes or modifies control measure(s) in the SIP only after the state has demonstrated that such a removal or modification will not interfere with attainment of the NAAQS, RFP, or any other applicable requirement of the CAA.

COMMENT #9: If in the event the start-up of a new source or modification to an existing source would not be applicable under PSD but would otherwise be an applicable source under this rescinded rule, the department should provide a demonstration of the potential emissions from such sources and make a determination about their potential impact on air quality.

COMMENT #10: The department could supplement this demonstration by providing information on why it believes no new or modified source will start-up (i.e., Are underbody deadeners no longer sprayed onto vehicles? If still spray applied, do they no longer have VOCs?).

COMMENT #11: The EPA notes that MACT subpart IIII for Surface Coating of Automobiles and Light-Duty Trucks has provisions for underbody anti-chip coatings and deadeners may provide a backstop.

The department could demonstrate that the associated limits on HAPs in the MACT subpart IIII also limit VOCs. The department may want to evaluate further to see if this MACT rule could address the proposed rescission of this RACT rule.

COMMENT #12: Additionally, the department's Redesignation Request and Maintenance Plan for the St. Louis, Missouri 2008 Ozone Standard Nonattainment Area is unclear whether this rule is relied upon to attain and maintain the standard. As such, the SIP revision submission for rescinding this rule should discuss any potential impact of rescinding the rule on that plan.

RESPONSE: The rescission of this RACT rule is consistent with Executive Order 17-03 requiring a review of every state regulation to affirm that the regulation is necessary. The review of this rule indicated there are no sources subject to the rule, making the rule obsolete. In this case, the source is no longer operating. This rescission will not have a negative effect on air quality since the rule does not function to reduce emission (no sources regulated) or achieve attainment or maintenance of the NAAQS (SIP requirements met). To address EPA's concern about limiting VOC emissions from a new source, the department reiterates that RACT rules were intended to apply to existing major sources in nonattainment areas present at the time of the rule's promulgation. Any new sources or major modifications of existing sources would not be subject to this RACT rule and instead would be subject to New Source Review permitting and current applicable state or federal rules. Those state and federal rules would serve as the backstop limiting VOC emissions. The rule is not relied upon for any SIP purposes since there are no affected sources.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 5—Air Quality Standards and Air Pollution
Control Rules Specific to the St. Louis Metropolitan Area

ORDER OF RULEMAKING

By the authority vested in the Missouri Air Conservation Commission under section 643.050, RSMo 2016, the commission rescinds a rule as follows:

10 CSR 10-5.410 Control of Emissions From Manufacture of Polystyrene Resin is rescinded.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on May 15, 2018 (43 MoReg 1020). No changes were made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Air Pollution Control Program received twelve (12) comments on this rulemaking from the U.S. Environmental Protection Agency (EPA).

Due to similar concerns expressed in the following five (5) comments, one (1) response that addresses these concerns is at the end of these five (5) comments.

COMMENT #1: The EPA provided a general comment for all the rules that the department has the responsibility to ensure that the State Implementation Plan (SIP) revision submitted to EPA meets the requirements of sections 110(1) and 193 of the Clean Air Act (CAA).

Section 110(1): Generally, section 110(1) provides that EPA cannot approve a SIP revision if the revision interferes with any applicable requirement concerning attainment and reasonable further progress (RFP) or any other requirement of the CAA. This section applies to any area and to any National Ambient Air Quality Standard (NAAQS) pollutant and/or precursor. Thus, any SIP rule is subject

to this section.

Section 193: Section 193 prohibits modification of a SIP in effect before 1990 unless that modification would ensure equivalent or greater emissions reductions, i.e., "anti-backsliding." Section 193 applies only to nonattainment areas and is specific to the nonattainment pollutant. The applicability of section 193 is specific to nonattainment "criteria" pollutants. The ozone implementation rule (codified at 40 CFR 51.905(a)(4)), describes how section 193 applies to Kansas City - an attainment area for the eight (8)-hour standard and maintenance area for the one (1)-hour standard.

Each of the eleven (11) proposed rule rescissions are subject to section 110(1) requirements; six (6) of the proposed rule rescissions are subject to the section 193 requirements. One (1) of the seven (7) proposed rule revisions is subject to section 110(1) requirements, one (1) is a Title V Part 70 revision, one (1) is a 111(d) plan revision and the remaining four (4) proposed rule revisions are administrative in nature only.

COMMENT #2: The EPA suggests a demonstration that quantifies any emissions increase or potential increase by rescinding the rule(s), and a discussion on the impact on air quality. This demonstration could be done by comparing the source inventory at the time the rule was promulgated to the source inventory now, and demonstrating the overall impact on emissions. In addition, the department could include a discussion of the monitored air quality when the rule was promulgated/incorporated into the SIP and monitored air quality trends that demonstrate an improvement in air quality and how the rescission of the rule might impact those trends.

COMMENT #3: The EPA suggests a discussion of the rule's purpose; specifically, whether the rule was promulgated to meet nonattainment area requirements, and if so, which specific NAAQS. In addition, the department could describe how the rule no longer serves to meet that purpose or how the rule has been superseded by another permanent and enforceable mechanism.

COMMENT #4: The EPA suggests a discussion of whether the rule was used to support other actions and whether the removal of the rule would impact those obligations such as an attainment demonstration, a request for a determination to attainment, a redesignation request and maintenance plan, or other actions such as Regional Haze or Interstate Transport.

COMMENT #5: The EPA suggests that where the department may be anticipating other federal programs, such as Maximum Achievable Control Technology (MACT) and National Emissions Standards for Hazardous Air Pollutants, as acting as a backstop to removal of its Reasonably Available Control Technology (RACT) rules, a comprehensive discussion of how those programs equal RACT. For example, there may be volatile organic compound (VOC) sources regulated by these programs that are well-controlled through add-on controls, or even through substitution of non-hazardous air pollutant material for VOC hazardous air pollutant (HAP) materials, however, these programs only cover air toxics and not all VOC emissions that RACT would capture and control are air toxics.

RESPONSE: The rescission of this rule is consistent with Executive Order 17-03 requiring a review of every regulation to affirm that the regulation is essential to the health, safety, or welfare of Missouri residents. The review of this rule indicated that no sources are subject to the rule, that the rule does not reduce any air pollutant, and therefore is not essential. Previously subject sources either have gone out of business or the source is no longer subject to the rule. In some cases, the source has been out of business or not subject to the rule for years. While a rule may have applied to a source to reduce or limit air pollutants in the past, the source is no longer producing the regulated emissions and the rule is no longer needed or relied upon for emission reductions going forward. To address EPA's concern about limiting VOC emissions from a new source, the department reiterates that RACT rules were intended to apply to existing major sources in nonattainment areas present at the time of the rule's promulgation. Any new source would not be subject to a RACT rule and instead would be subject to current applicable state or federal rules. Those state and federal rules would serve as the backstop limiting

VOC emissions. These rules are not relied upon for any SIP purposes.

Due to similar concerns expressed in the following seven (7) comments, one (1) response that addresses these concerns is at the end of these seven (7) comments.

COMMENT #6: The Rulemaking Report indicates that “the rule applied Reasonably Available Control Technology (RACT) to major sources of volatile organic compounds (VOC) emissions from polystyrene resin manufacturers in the St. Louis nonattainment area. Generally, RACT rules apply to those sources that were subject because they existed at the time the RACT rule became effective and are still currently operating.” The Rulemaking Report names Dow Chemical Company as the only applicable source and states that because the company doesn’t manufacture resin anymore, the rule is no longer applicable. However, the rule language indicates that the rule applies throughout St. Louis City and Jefferson, St. Charles, Franklin, and St. Louis counties and that it applies to all installations engaged in the manufacture of polystyrene resin. Because the rule does not specifically say if it would or would not apply to a new or modified manufacturer of polystyrene resin upon start-up, and the rule could read to imply that it would, the department should provide clarification of the rule’s applicability and demonstrate that the SIP revision would not interfere with attainment of the NAAQS.

COMMENT #7: A potential way for the department to demonstrate that the SIP revision would not interfere with attainment of the NAAQS might be to provide an explanation of how its SIP-approved Prevention of Significant Deterioration (PSD) program would ensure that the start-up of a new source or modification of an existing source would be controlled in an equivalent manner as would be required by the rescinded rule.

COMMENT #8: If EPA’s proposed rulemaking to redesignate the Missouri portion of the St. Louis-St. Charles-Farmington, MO-IL 2008 ozone area to attainment is finalized as proposed, Nonattainment New Source Review (NNSR) will no longer apply in Jefferson County and portions of Franklin County and new sources in those counties will then have a potential to emit of up to two hundred forty-nine (249) tons per year (tpy) without being subject to PSD, MACT, or New Source Performance Standards. Because of the change in applicability of NNSR, the department will need to ensure that the department’s SIP submission meets the requirements of sections 110(1) and 193 of the CAA, also known as the “anti-backsliding” provisions. These sections relate to EPA’s authority to approve a SIP revision that removes or modifies control measure(s) in the SIP only after the state has demonstrated that such a removal or modification will not interfere with attainment of the NAAQS, RFP, or any other applicable requirement of the CAA.

COMMENT #9: If in the event the start-up of a new source or modification to an existing source would not be applicable under PSD or NNSR but would otherwise be an applicable source under the rescinded rule, the department should provide a demonstration of the potential emissions from such sources and make a determination about their potential impact on air quality.

COMMENT #10: The department could supplement this demonstration by providing information on why it believes no new or modified sources will start-up (i.e., Is polystyrene resin no longer produced? If the resin is produced, does manufacturing it no longer emit VOCs?).

COMMENT #11: The EPA notes that the MACT subpart JJJ Group IV Polymers and Resins has provisions for polystyrene resins which may provide a backstop. The department could demonstrate that the associated limits on HAPs in the MACT subpart JJJ also limit VOCs. The department may want to evaluate further to see if this MACT rule could address the proposed rescission of this RACT rule.

COMMENT #12: Additionally, the department’s Redesignation Request and Maintenance Plan for the St. Louis, Missouri 2008 Ozone Standard Nonattainment Area is unclear whether this rule is relied upon to attain and maintain the standard. As such, the SIP revision submission for rescinding this rule should discuss any potential

impact of rescinding the rule on that plan.

RESPONSE: The rescission of this RACT rule is consistent with Executive Order 17-03 requiring a review of every state regulation to affirm that the regulation is necessary. The review of this rule indicated there are no sources subject to the rule, making the rule obsolete. In this case, the source is no longer manufacturing polystyrene resin. This rescission will not have a negative effect on air quality since the rule does not function to reduce emissions (no sources regulated) or achieve attainment or maintenance of the NAAQS (SIP requirements met). To address EPA’s concern about limiting VOC emissions from a new source, the department reiterates that RACT rules were intended to apply to existing major sources in nonattainment areas present at the time of the rule’s promulgation. Any new sources or major modifications of existing sources would not be subject to this RACT rule and instead would be subject to New Source Review permitting and current applicable state or federal rules. Those state and federal rules would serve as the backstop limiting VOC emissions. The rule is not relied upon for any SIP purposes since there are no affected sources.

Title 10—DEPARTMENT OF NATURAL RESOURCES

Division 10—Air Conservation Commission

Chapter 5—Air Quality Standards and Air Pollution Control Rules Specific to the St. Louis Metropolitan Area

ORDER OF RULEMAKING

By the authority vested in the Missouri Air Conservation Commission under section 643.050, RSMo 2016, the commission rescinds a rule as follows:

10 CSR 10-5.440 Control of Emissions From Bakery Ovens is rescinded.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on May 15, 2018 (43 MoReg 1020). No changes were made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources’ Air Pollution Control Program received eleven (11) comments on this rulemaking from the U.S. Environmental Protection Agency (EPA).

Due to similar concerns expressed in the following five (5) comments, one (1) response that addresses these concerns is at the end of these five (5) comments.

COMMENT #1: The EPA provided a general comment for all the rules that the department has the responsibility to ensure that the State Implementation Plan (SIP) revision submitted to EPA meets the requirements of sections 110(1) and 193 of the Clean Air Act (CAA).

Section 110(1): Generally, section 110(1) provides that EPA cannot approve a SIP revision if the revision interferes with any applicable requirement concerning attainment and reasonable further progress (RFP) or any other requirement of the CAA. This section applies to any area and to any National Ambient Air Quality Standard (NAAQS) pollutant and/or precursor. Thus, any SIP rule is subject to this section.

Section 193: Section 193 prohibits modification of a SIP in effect before 1990 unless that modification would ensure equivalent or greater emissions reductions, i.e., “anti-backsliding.” Section 193 applies only to nonattainment areas and is specific to the nonattainment pollutant. The applicability of section 193 is specific to nonattainment “criteria” pollutants. The ozone implementation rule (codified at 40 CFR 51.905(a)(4)), describes how section 193 applies to

Kansas City - an attainment area for the eight (8)-hour standard and maintenance area for the one (1)-hour standard.

Each of the eleven (11) proposed rule rescissions are subject to section 110(1) requirements; six (6) of the proposed rule rescissions are subject to the section 193 requirements. One (1) of the seven (7) proposed rule revisions is subject to section 110(1) requirements, one (1) is a Title V Part 70 revision, one (1) is a 111(d) plan revision and the remaining four (4) proposed rule revisions are administrative in nature only.

COMMENT #2: The EPA suggests a demonstration that quantifies any emissions increase or potential increase by rescinding the rule(s), and a discussion on the impact on air quality. This demonstration could be done by comparing the source inventory at the time the rule was promulgated to the source inventory now, and demonstrating the overall impact on emissions. In addition, the department could include a discussion of the monitored air quality when the rule was promulgated/incorporated into the SIP and monitored air quality trends that demonstrate an improvement in air quality and how the rescission of the rule might impact those trends.

COMMENT #3: The EPA suggests a discussion of the rule's purpose; specifically, whether the rule was promulgated to meet nonattainment area requirements, and if so, which specific NAAQS. In addition, the department could describe how the rule no longer serves to meet that purpose or how the rule has been superseded by another permanent and enforceable mechanism.

COMMENT #4: The EPA suggests a discussion of whether the rule was used to support other actions and whether the removal of the rule would impact those obligations such as an attainment demonstration, a request for a determination to attainment, a redesignation request and maintenance plan, or other actions such as Regional Haze or Interstate Transport.

COMMENT #5: The EPA suggests that where the department may be anticipating other federal programs, such as Maximum Achievable Control Technology (MACT) and National Emissions Standards for Hazardous Air Pollutants, as acting as a backstop to removal of its Reasonably Available Control Technology (RACT) rules, a comprehensive discussion of how those programs equal RACT. For example, there may be volatile organic compound (VOC) sources regulated by these programs that are well-controlled through add-on controls, or even through substitution of non-hazardous air pollutant material for VOC hazardous air pollutant materials, however, these programs only cover air toxics and not all VOC emissions that RACT would capture and control are air toxics.

RESPONSE: The rescission of this rule is consistent with Executive Order 17-03 requiring a review of every regulation to affirm that the regulation is essential to the health, safety, or welfare of Missouri residents. The review of this rule indicated that no sources are subject to the rule, that the rule does not reduce any air pollutant, and therefore is not essential. Previously subject sources either have gone out of business or the source is no longer subject to the rule. In some cases, the source has been out of business or not subject to the rule for years. While a rule may have applied to a source to reduce or limit air pollutants in the past, the source is no longer producing the regulated emissions and the rule is no longer needed or relied upon for emission reductions going forward. To address EPA's concern about limiting VOC emissions from a new source, the department reiterates that RACT rules were intended to apply to existing major sources in nonattainment areas present at the time of the rule's promulgation. Any new source would not be subject to a RACT rule and instead would be subject to current applicable state or federal rules. Those state and federal rules would serve as the backstop limiting VOC emissions. These rules are not relied upon for any SIP purposes.

Due to similar concerns expressed in the following six (6) comments, one (1) response that addresses these concerns is at the end of these six (6) comments.

COMMENT #6: The Rulemaking Report indicates that "the rule

applied Reasonably Available Control Technology (RACT) to major sources of volatile organic compounds (VOC) emissions from bakery ovens at large commercial bakeries in the St. Louis nonattainment area. Generally, RACT rules apply to those sources that were subject because they existed at the time the RACT rule became effective and are still currently operation." The Rulemaking Report identifies Hostess as the only applicable source and states that the facility was closed in 2012, making the rule obsolete. However, the rule language indicates that the rule applies to any new or existing installation in the counties of St. Charles, St. Louis, Franklin, or Jefferson or the City of St. Louis that have emissions of greater than one hundred (100) tons per year (tpy) of VOCs. The department should provide a demonstration that the SIP revision would not interfere with attainment of the NAAQS.

COMMENT #7: A potential way for the department to demonstrate that the SIP revision would not interfere with attainment of the NAAQS might be provide explanation of how its SIP-approved Prevention of Significant Deterioration (PSD) program would ensure that the start-up of a new source or modification of an existing source would be controlled in an equivalent manner as would be required by the rescinded rule.

COMMENT #8: If EPA's proposed rulemaking to redesignate the Missouri portion of the St. Louis-St. Charles-Farmington, MO-IL 2008 ozone area to attainment is finalized as proposed, Nonattainment New Source Review (NNSR) will no longer apply in Jefferson County and portions of Franklin County and new sources in those counties will then have a potential to emit of up to two hundred forty-nine (249) tpy without being subject to PSD, MACT, or New Source Performance Standards. Because of the change in applicability of NNSR, the department will need to ensure that the department's SIP submission meets the requirements of sections 110(1) and 193 of the CAA, also known as the "anti-backsliding" provisions. These sections relate to EPA's authority to approve a SIP revision that removes or modifies control measure(s) in the SIP only after the state has demonstrated that such a removal or modification will not interfere with attainment of the NAAQS, RFP, or any other applicable requirement of the CAA.

COMMENT #9: If in the event the start-up of a new source or modification to an existing source would not be applicable under PSD or NNSR but would otherwise be an applicable source under the rescinded rule, the department should provide a demonstration of the potential emissions from such sources and make a determination about their potential impact on air quality.

COMMENT #10: The department could supplement this demonstration by providing information on why it believes no new or modified sources will start-up (i.e., Do bakery ovens no longer emit VOCs?).

COMMENT #11: Additionally, the department's Redesignation Request and Maintenance Plan for the St. Louis, Missouri 2008 Ozone Standard Nonattainment Area is unclear whether this rule is relied upon to attain and maintain the standard. As such, the SIP revision submission for rescinding this rule should discuss any potential impact of rescinding the rule on that plan.

RESPONSE: The rescission of this RACT rule is consistent with Executive Order 17-03 requiring a review of every state regulation to affirm that the regulation is necessary. The review of this rule indicated there are no sources subject to the rule, making the rule obsolete. In this case, the source is no longer operating. This rescission will not have a negative effect on air quality since the rule does not function to reduce emissions (no sources regulated) or achieve attainment or maintenance of the NAAQS (SIP requirements met). To address EPA's concern about limiting VOC emissions from a new source, the department reiterates that RACT rules were intended to apply to existing major sources in nonattainment areas present at the time of the rule's promulgation. Any new sources or major modifications of existing sources would not be subject to this RACT rule and instead would be subject to New Source Review permitting and current applicable state or federal rules. Those state and federal rules would serve as the backstop limiting VOC emissions. The rule is not relied upon for any SIP purposes since there are no affected sources.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 5—Air Quality Standards and Air Pollution
Control Rules Specific to the St. Louis Metropolitan Area

ORDER OF RULEMAKING

By the authority vested in the Missouri Air Conservation Commission under section 643.050, RSMo 2016, the commission rescinds a rule as follows:

10 CSR 10-5.455 Control of Emissions From Industrial Solvent Cleaning Operations is rescinded.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on May 15, 2018 (43 MoReg 1020–1021). No changes were made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Air Pollution Control Program received twelve (12) comments on this rulemaking from the U.S. Environmental Protection Agency (EPA).

Due to similar concerns expressed in the following five (5) comments, one (1) response that addresses these concerns is at the end of these five (5) comments.

COMMENT #1: The EPA provided a general comment for all the rules that the department has the responsibility to ensure that the State Implementation Plan (SIP) revision submitted to EPA meets the requirements of sections 110(1) and 193 of the Clean Air Act (CAA).

Section 110(1): Generally, section 110(1) provides that EPA cannot approve a SIP revision if the revision interferes with any applicable requirement concerning attainment and reasonable further progress (RFP) or any other requirement of the CAA. This section applies to any area and to any National Ambient Air Quality Standard (NAAQS) pollutant and/or precursor. Thus, any SIP rule is subject to this section.

Section 193: Section 193 prohibits modification of a SIP in effect before 1990 unless that modification would ensure equivalent or greater emissions reductions, i.e., "anti-backsliding." Section 193 applies only to nonattainment areas and is specific to the nonattainment pollutant. The applicability of section 193 is specific to nonattainment "criteria" pollutants. The ozone implementation rule (codified at 40 CFR 51.905(a)(4)), describes how section 193 applies to Kansas City - an attainment area for the eight (8)-hour standard and maintenance area for the one (1)-hour standard.

Each of the eleven (11) proposed rule rescissions are subject to section 110(1) requirements; six (6) of the proposed rule rescissions are subject to the section 193 requirements. One (1) of the seven (7) proposed rule revisions is subject to section 110(1) requirements, one (1) is a Title V Part 70 revision, one (1) is a 111(d) plan revision and the remaining four (4) proposed rule revisions are administrative in nature only.

COMMENT #2: The EPA suggests a demonstration that quantifies any emissions increase or potential increase by rescinding the rule(s), and a discussion on the impact on air quality. This demonstration could be done by comparing the source inventory at the time the rule was promulgated to the source inventory now, and demonstrating the overall impact on emissions. In addition, the department could include a discussion of the monitored air quality when the rule was promulgated/incorporated into the SIP and monitored air quality trends that demonstrate an improvement in air quality and how the rescission of the rule might impact those trends.

COMMENT #3: The EPA suggests a discussion of the rule's purpose; specifically, whether the rule was promulgated to meet nonat-

tainment area requirements, and if so, which specific NAAQS. In addition, the department could describe how the rule no longer serves to meet that purpose or how the rule has been superseded by another permanent and enforceable mechanism.

COMMENT #4: The EPA suggests a discussion of whether the rule was used to support other actions and whether the removal of the rule would impact those obligations such as an attainment demonstration, a request for a determination to attainment, a redesignation request and maintenance plan, or other actions such as Regional Haze or Interstate Transport.

COMMENT #5: The EPA suggests that where the department may be anticipating other federal programs, such as Maximum Achievable Control Technology (MACT) and National Emissions Standards for Hazardous Air Pollutants, as acting as a backstop to removal of its Reasonably Available Control Technology (RACT) rules, a comprehensive discussion of how those programs equal RACT. For example, there may be volatile organic compound (VOC) sources regulated by these programs that are well-controlled through add-on controls, or even through substitution of non-hazardous air pollutant material for VOC hazardous air pollutant (HAP) materials, however, these programs only cover air toxics and not all VOC emissions that RACT would capture and control are air toxics.

RESPONSE: The rescission of this rule is consistent with Executive Order 17-03 requiring a review of every regulation to affirm that the regulation is essential to the health, safety, or welfare of Missouri residents. The review of this rule indicated that no sources are subject to the rule, that the rule does not reduce any air pollutant, and therefore is not essential. Previously subject sources either have gone out of business or the source is no longer subject to the rule. In some cases, the source has been out of business or not subject to the rule for years. While a rule may have applied to a source to reduce or limit air pollutants in the past, the source is no longer producing the regulated emissions and the rule is no longer needed or relied upon for emission reductions going forward. To address EPA's concern about limiting VOC emissions from a new source, the department reiterates that RACT rules were intended to apply to existing major sources in nonattainment areas present at the time of the rule's promulgation. Any new source would not be subject to a RACT rule and instead would be subject to current applicable state or federal rules. Those state and federal rules would serve as the backstop limiting VOC emissions. These rules are not relied upon for any SIP purposes.

Due to similar concerns expressed in the following seven (7) comments, one (1) response that addresses these concerns is at the end of these seven (7) comments.

COMMENT #6: The Rulemaking Report indicates that the "rule applied Reasonably Available Control Technology (RACT) to major sources of volatile organic compounds (VOC) emissions from the use of large quantities of solvent cleaners in the St. Louis nonattainment area. Generally, RACT rules apply to those sources that were subject because they existed at the time the RACT rule became effective and are still currently operating." The Rulemaking Report says that the originally subject source is now exempt, making the rule obsolete (it does not identify the originally subject source). The rule language indicates that it applies to any person who performs or allows the performance of any cleaning operation involving the use of organic solvents or solvent solutions and unless exempt from the rule, the provisions apply to any stationary source that emits at least three (3) tons per twelve (12)-month rolling period or more of VOCs from cleaning operations at the source, in the absence of air pollution control equipment, and stores and/or disposes of these solvent materials. The rule language states that it applies throughout St. Louis City and the counties of Jefferson, St. Charles, Franklin, and St. Louis. Because the rule, as written, does not specifically say if it would or would not apply to a new or modified solvent cleaning operation, and the rule could read to imply that it would, the department should provide clarification of the rule's applicability and demonstrate that the SIP revision would not interfere with attainment of the NAAQS.

COMMENT #7: A potential way for the department to demonstrate that the SIP revision would not interfere with attainment of the NAAQS might be provide explanation of how its SIP-approved Prevention of Significant Deterioration (PSD) program or Nonattainment New Source Review (NNSR) program would ensure that the start-up of a new source or modification of an existing source would be controlled in an equivalent manner as would be required by the rescinded rule.

COMMENT #8: If EPA's proposed rulemaking to redesignate the Missouri portion of the St. Louis-St. Charles-Farmington, MO-IL 2008 ozone area to attainment is finalized as proposed, NNSR will no longer apply in Jefferson County and portions of Franklin County and new sources in those counties will then have a potential to emit of up to two hundred forty-nine (249) tons per year without being subject to PSD, MACT, or New Source Performance Standards. Because of the change in applicability of NNSR, the department will need to ensure that the department's SIP submission meets the requirements of sections 110(1) and 193 of the CAA, also known as the "anti-backsliding" provisions. These sections relate to EPA's authority to approve a SIP revision that removes or modifies control measure(s) in the SIP only after the state has demonstrated that such a removal or modification will not interfere with attainment of the NAAQS, RFP, or any other applicable requirement of the CAA.

COMMENT #9: If in the event the start-up of a new source or modification to an existing source would not be applicable under PSD or NNSR, but would otherwise be an applicable source under the rescinded rule, the department should provide a demonstration of the potential emissions from such sources and make a determination about their potential impact on air quality.

COMMENT #10: The department could supplement this demonstration by providing information on why it believes no new or modified sources will start-up (i.e., Are solvent cleanup operations no longer performed, or do those operations always meet one (1) of the exceptions to the rescinded rule? Do solvent clean-up operations no longer use VOCs?).

COMMENT #11: The department could demonstrate that the associate limits on HAPs also limit VOCs and notes that the MACT subpart T for Halogenated Solvent Cleaning has provisions that may provide a backstop. The department may want to evaluate further to see if this MACT rule could address the proposed rescission of this RACT rule, although many of the halogenated solvents are specifically not VOCs (i.e., the MACT regulates six (6) solvents specifically and only two (2) of those are VOCs).

COMMENT #12: Additionally, the department's Redesignation Request and Maintenance Plan for the St. Louis (Missouri) 2008 Ozone Standard Nonattainment Area is unclear whether this rule is relied upon to attain and maintain the standard. As such, the SIP revision submission for rescinding this rule should discuss any potential impact of rescinding the rule on that plan.

RESPONSE: The rescission of this RACT rule is consistent with Executive Order 17-03 requiring a review of every state regulation to affirm that the regulation is necessary. The review of this rule indicated there are no sources subject to the rule, making the rule obsolete. In this case, the source is exempt from the rule according to their current operating permit because the facility is already subject to a different RACT rule for auto and light-duty truck assembly coatings. This rescission will not have a negative effect on air quality since the rule does not function to reduce emissions (no sources regulated) or achieve attainment or maintenance of the NAAQS (SIP requirements met). To address EPA's concern about limiting VOC emissions from a new source, the department reiterates that RACT rules were intended to apply to existing major sources in nonattainment areas present at the time of the rule's promulgation. Any new sources or major modifications of existing sources would not be subject to this RACT rule and instead would be subject to New Source Review permitting and current applicable state or federal rules. Those state and federal rules would serve as the backstop limiting VOC emissions. The rule is not relied upon for any SIP purposes since there are no affected sources.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 5—Air Quality Standards and Air Pollution
Control Rules Specific to the St. Louis Metropolitan Area

ORDER OF RULEMAKING

By the authority vested in the Missouri Air Conservation Commission under section 643.050, RSMo 2016, the commission rescinds a rule as follows:

10 CSR 10-5.520 Control of Volatile Organic Compound Emissions From Existing Major Sources is rescinded.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on May 15, 2018 (43 MoReg 1021). No changes were made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Air Pollution Control Program received eleven (11) comments on this rulemaking from the U.S. Environmental Protection Agency (EPA).

Due to similar concerns expressed in the following five (5) comments, one (1) response that addresses these concerns is at the end of these five (5) comments.

COMMENT #1: The EPA provided a general comment for all the rules that the department has the responsibility to ensure that the State Implementation Plan (SIP) revision submitted to EPA meets the requirements of sections 110(1) and 193 of the Clean Air Act (CAA).

Section 110(1): Generally, section 110(1) provides that EPA cannot approve a SIP revision if the revision interferes with any applicable requirement concerning attainment and reasonable further progress (RFP) or any other requirement of the CAA. This section applies to any area and to any National Ambient Air Quality Standard (NAAQS) pollutant and/or precursor. Thus, any SIP rule is subject to this section.

Section 193: Section 193 prohibits modification of a SIP in effect before 1990 unless that modification would ensure equivalent or greater emissions reductions, i.e., "anti-backsliding." Section 193 applies only to nonattainment areas and is specific to the nonattainment pollutant. The applicability of section 193 is specific to nonattainment "criteria" pollutants. The ozone implementation rule (codified at 40 CFR 51.905(a)(4)), describes how section 193 applies to Kansas City - an attainment area for the eight (8)-hour standard and maintenance area for the one (1)-hour standard.

Each of the eleven (11) proposed rule rescissions are subject to section 110(1) requirements; six (6) of the proposed rule rescissions are subject to the section 193 requirements. One (1) of the seven (7) proposed rule revisions is subject to section 110(1) requirements, one (1) is a Title V Part 70 revision, one (1) is a 111(d) plan revision and the remaining four (4) proposed rule revisions are administrative in nature only.

COMMENT #2: The EPA suggests a demonstration that quantifies any emissions increase or potential increase by rescinding the rule(s), and a discussion on the impact on air quality. This demonstration could be done by comparing the source inventory at the time the rule was promulgated to the source inventory now, and demonstrating the overall impact on emissions. In addition, the department could include a discussion of the monitored air quality when the rule was promulgated/incorporated into the SIP and monitored air quality trends that demonstrate an improvement in air quality and how the rescission of the rule might impact those trends.

COMMENT #3: The EPA suggests a discussion of the rule's purpose; specifically, whether the rule was promulgated to meet nonattainment

area requirements, and if so, which specific NAAQS. In addition, the department could describe how the rule no longer serves to meet that purpose or how the rule has been superseded by another permanent and enforceable mechanism.

COMMENT #4: The EPA suggests a discussion of whether the rule was used to support other actions and whether the removal of the rule would impact those obligations such as an attainment demonstration, a request for a determination to attainment, a redesignation request and maintenance plan, or other actions such as Regional Haze or Interstate Transport.

COMMENT #5: The EPA suggests that where the department may be anticipating other federal programs, such as Maximum Achievable Control Technology and National Emissions Standards for Hazardous Air Pollutants, as acting as a backstop to removal of its Reasonably Available Control Technology (RACT) rules, a comprehensive discussion of how those programs equal RACT. For example, there may be volatile organic compound (VOC) sources regulated by these programs that are well-controlled through add-on controls, or even through substitution of non-hazardous air pollutant material for VOC hazardous air pollutant materials, however, these programs only cover air toxics and not all VOC emissions that RACT would capture and control are air toxics.

RESPONSE: The rescission of this rule is consistent with Executive Order 17-03 requiring a review of every regulation to affirm that the regulation is essential to the health, safety, or welfare of Missouri residents. The review of this rule indicated that no sources are subject to the rule, that the rule does not reduce any air pollutant, and therefore is not essential. Previously subject sources either have gone out of business or the source is no longer subject to the rule. In some cases, the source has been out of business or not subject to the rule for years. While a rule may have applied to a source to reduce or limit air pollutants in the past, the source is no longer producing the regulated emissions and the rule is no longer needed or relied upon for emission reductions going forward. To address EPA's concern about limiting VOC emissions from a new source, the department reiterates that RACT rules were intended to apply to existing major sources in nonattainment areas present at the time of the rule's promulgation. Any new source would not be subject to a RACT rule and instead would be subject to current applicable state or federal rules. Those state and federal rules would serve as the backstop limiting VOC emissions. These rules are not relied upon for any SIP purposes.

Due to similar concerns expressed in the following six (6) comments, one (1) response that addresses these concerns is at the end of these six (6) comments.

COMMENT #6: The Rulemaking Report indicates that the proposed action will rescind an unnecessary regulation because no sources are subject to this rule. This rule was created to help bring the St. Louis ozone nonattainment area into compliance by reducing VOCs from sources that were not affected by other rulemakings. However, the rule language indicates that the rule applies to any installation in the counties of St. Charles, St. Louis, Franklin, or Jefferson or the City of St. Louis that have the potential to emit (PTE) greater than one-hundred (100) tons per year (tpy) of VOCs and that are not subject to one (1) of three (3) exemptions in the rule. Because the rule, as written, does not specifically say if it would or would not apply to a new or modified source with the PTE greater than one-hundred (100) tpy of VOCs upon start-up, and the rule could read to imply that it would, the department should provide clarification of the rule's applicability and demonstrate that the SIP revision would not interfere with attainment of the NAAQS.

COMMENT #7: A potential way for the department to demonstrate that this SIP revision would not interfere with attainment of the NAAQS might be to provide an explanation of how its SIP approved Prevention of Significant Deterioration (PSD) program would ensure that the start-up of a new source or modification of an existing source would be controlled in at least an equivalent manner as would be

required by this rescinded rule.

COMMENT #8: If the EPA's proposed rulemaking to redesignate the Missouri portion of the St. Louis-St. Charles-Farmington, MO-IL 2008 ozone area to attainment is finalized as proposed, Nonattainment New Source Review (NNSR) will no longer apply in Jefferson County and portions of Franklin County and new sources in those counties will then have a PTE of up to two-hundred forty-nine (249) tpy without being subject to PSD, MACT, or NSPS. Because of the change in applicability of NNSR, the department will need to ensure that the department's SIP submission meets the requirements of sections 110(1) and 193 of the CAA, also known as the "anti-backsliding" provisions. These sections relate to EPA's authority to approve a SIP revision that removes or modifies control measure(s) in the SIP only after the state has demonstrated that such a removal or modification will not interfere with attainment of the NAAQS, RFP, or any other applicable requirement of the CAA.

COMMENT #9: If in the event the start-up of a new source or modification to an existing source would not be applicable under PSD but would otherwise be an applicable source under this rescinded rule, the department should provide a demonstration of the potential emissions from such sources and make a determination about their potential impact on air quality.

COMMENT #10: The department could supplement this demonstration by providing information on why it believes no new or modified source will start-up [i.e., Are there no sources that have PTE greater than one-hundred (100) tpy VOCs?].

COMMENT #11: Additionally, the department's Redesignation Request and Maintenance Plan for the St. Louis, Missouri 2008 Ozone Standard Nonattainment Area is unclear whether this rule is relied upon to attain and maintain the standard. As such, the SIP revision submission for rescinding this rule should discuss any potential impact of rescinding the rule on that plan.

RESPONSE: The rescission of this RACT rule is consistent with Executive Order 17-03 requiring a review of every state regulation to affirm that the regulation is necessary. The review of this rule indicated there are no sources subject to the rule, making the rule obsolete. This rescission will not have a negative effect on air quality since the rule does not function to reduce emission (no sources regulated) or achieve attainment or maintenance of the NAAQS (SIP requirements met). To address EPA's concern about limiting VOC emissions from a new source, the department reiterates that RACT rules were intended to apply to existing major sources in nonattainment areas present at the time of the rule's promulgation. Any new sources or major modifications of existing sources would not be subject to this RACT rule and instead would be subject to New Source Review permitting and current applicable state or federal rules. Those state and federal rules would serve as the backstop limiting VOC emissions. The rule is not relied upon for any SIP purposes since there are no affected sources.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 5—Air Quality Standards and Air Pollution
Control Rules Specific to the St. Louis Metropolitan Area

ORDER OF RULEMAKING

By the authority vested in the Missouri Air Conservation Commission under section 643.050, RSMo 2016, the commission amends a rule as follows:

10 CSR 10-5.570 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on May 15, 2018 (43 MoReg 1021-1024). Those sections with changes are reprinted

here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Air Pollution Control Program received sixteen (16) comments on this rulemaking from the U.S. Environmental Protection Agency (EPA).

Due to similar concerns expressed in the following five (5) comments, one (1) response that addresses these concerns is at the end of these five (5) comments.

COMMENT #1: The EPA provided a general comment for all the rules that the department has the responsibility to ensure that the State Implementation Plan (SIP) revision submitted to EPA meets the requirements of sections 110(1) and 193 of the Clean Air Act (CAA).

Section 110(1): Generally, section 110(1) provides that EPA cannot approve a SIP revision if the revision interferes with any applicable requirement concerning attainment and reasonable further progress or any other requirement of the CAA. This section applies to any area and to any National Ambient Air Quality Standard (NAAQS) pollutant and/or precursor. Thus, any SIP rule is subject to this section.

Section 193: Section 193 prohibits modification of a SIP in effect before 1990 unless that modification would ensure equivalent or greater emissions reductions, i.e. "anti-backsliding." Section 193 applies only to nonattainment areas and is specific to the nonattainment pollutant. The applicability of section 193 is specific to nonattainment "criteria" pollutants. The ozone implementation rule (codified at 40 CFR 51.905(a)(4)), describes how section 193 applies to Kansas City - an attainment area for the eight (8)-hour standard and maintenance area for the one (1)-hour standard.

Each of the eleven (11) proposed rule rescissions are subject to section 110(1) requirements; six (6) of the proposed rule rescissions are subject to the section 193 requirements. One (1) of the seven (7) proposed rule revisions is subject to section 110(1) requirements, one (1) is a Title V Part 70 revision, one (1) is a 111(d) plan revision and the remaining four (4) proposed rule revisions are administrative in nature only.

COMMENT #2: The EPA suggests a demonstration that quantifies any emissions increase or potential increase by rescinding the rule(s), and a discussion on the impact on air quality. This demonstration could be done by comparing the source inventory at the time the rule was promulgated to the source inventory now, and demonstrating the overall impact on emissions. In addition, the department could include a discussion of the monitored air quality when the rule was promulgated/incorporated into the SIP and monitored air quality trends that demonstrate an improvement in air quality and how the rescission of the rule might impact those trends.

COMMENT #3: The EPA suggests a discussion of the rule's purpose; specifically, whether the rule was promulgated to meet nonattainment area requirements, and if so, which specific NAAQS. In addition, the department could describe how the rule no longer serves to meet that purpose or how the rule has been superseded by another permanent and enforceable mechanism.

COMMENT #4: The EPA suggests a discussion of whether the rule was used to support other actions and whether the removal of the rule would impact those obligations such as an attainment demonstration, a request for a determination to attainment, a redesignation request and maintenance plan, or other actions such as Regional Haze or Interstate Transport.

COMMENT #5: The EPA suggests that where the department may be anticipating other federal programs, such as Maximum Achievable Control Technology and National Emissions Standards for Hazardous Air Pollutants, as acting as a backstop to removal of its Reasonably Available Control Technology (RACT) rules, a comprehensive discussion of how those programs equal RACT. For example, there may be volatile organic compound (VOC) sources regulated by these programs that are well-controlled through add-on controls, or

even through substitution of non-hazardous air pollutant material for VOC hazardous air pollutant materials, however, these programs only cover air toxics and not all VOC emissions that RACT would capture and control are air toxics.

RESPONSE: The amendment of the rule is consistent with Executive Order 17-03 requiring a review of every regulation to affirm that the regulation is essential to the health, safety, or welfare of Missouri residents. Emissions will not increase with the proposed rule amendment and the revision will meet CAA sections 110(1) and 193 requirements. There is no negative impact on air quality. The department is not anticipating the use of other federal programs as a backstop because the department is not rescinding this rule. No changes were made to the rule text as a result of this comment.

COMMENT #6: The EPA recommends that the department reconsider adding the incorporation by reference of 40 CFR 60, 40 CFR 61, and 40 CFR 65 in whole in subsection (2)(C) (the definition for "gaseous fuel"). It would be unusual for a state to adopt these parts of the *Code of Federal Regulations* (CFR) in whole. If the federal definitions are absent or differ from those found in 10 CSR 10-6.020 Definitions and Common Reference Tables or 10 CSR 10-5.570(2)(C), for clarity, EPA recommends that the full text of the definition be included at subsection (2)(C), or even 10 CSR 10-6.020 Definitions and Common Reference Tables rather than incorporated by reference in whole. If the department intends to keep the incorporations by reference of 40 CFR 60, 40 CFR 61, and 40 CFR 65 in the rule but did not intend for the incorporations to apply only to the definition for "gaseous fuel" at subsection (2)(C), then EPA recommends that the department move it to another location in the rule text.

RESPONSE AND EXPLANATION OF CHANGE: As a result of this comment, "blast furnace gases" and "process gases" that are regulated in 40 CFR 60, 40 CFR 61, and 40 CFR 65 will not be included for exemption in the definition of "gaseous fuel" and subsection (2)(C) will be updated to reflect this.

COMMENT #7: There are several references to 10 CSR 10-6.030(22) however, section (22) does not exist in the state's 10 CSR 10-6.030 Sampling Methods. The EPA understands that the department is in the process of revising 10 CSR 10-6.030 Sampling Methods and that those potential rule changes are currently available for public comment. As such, EPA would not act on a SIP submission revising 10 CSR 10-5.570 until a SIP submission has been made to EPA for 10 CSR 10-6.030.

RESPONSE: The department is currently in the process of amending rule 10 CSR 10-6.030 Sampling Methods for Air Pollution Sources and plans to submit this rule for inclusion into the SIP before, or concurrently with, the submittal to EPA of amendments to 10 CSR 10-5.570. As a result of this comment, no changes were made to the rule text.

COMMENT #8: The EPA encourages the department to assess the need for adding a reference to 10 CSR 10-6.030(22) in paragraph (3)(B)1. of this rule because the paragraph already specifies which test methods to use (Methods 6, 6A, 6B, or 6C) and where the methods can be found (40 CFR 60, Appendix A). The draft rule text language for the potential revisions to 10 CSR 10-6.030 adds section (22), which incorporates 40 CFR 60 in whole by reference. It may be unnecessary to divert the public to another state regulation that incorporates a federal regulation by reference and provides no additional clarity than what is already specified in paragraph (3)(B)1.

RESPONSE: The department appreciates this comment and for all air rules found in 10 CSR 10-Chapters 1-6, where stack testing methods or guidance documents are mentioned more than once, a reference to rule 10 CSR 10-6.030 reduces the length of federal content incorporated by reference into these rules. As a result of this comment, no changes were made to the rule text.

COMMENT #9: There is a reference at paragraph (3)(B)2. to 10

CSR 10-6.040 Reference Methods however, the American Society for Testing and Material (ASTM) methods that are referenced in the rule do not yet exist in the state's 10 CSR 10-6.040. The EPA understands that the department is in the process of revising 10 CSR 10-6.040 and that those potential rule changes are currently available for public comment. As such, EPA would not act on a SIP submission revising 10 CSR 10-5.570 until a SIP submission has been made to EPA for 10 CSR 10-6.040.

RESPONSE: The department is currently in the process of amending rule 10 CSR 10-6.040 Reference Methods and plans to submit this rule for inclusion into the SIP before, or concurrently with, the submittal to EPA of amendments to 10 CSR 10-5.570. As a result of this comment, no changes were made to the rule text.

COMMENT #10: The EPA encourages the department to assess the need for adding a reference to 10 CSR 10-6.030(22) in subparagraph (3)(D)1.A. because the subparagraph already specifies the applicable requirements of the continuous emissions monitoring system (CEMS) can be found at 40 CFR 60, Appendix B. The draft rule text language for the potential revisions to 10 CSR 10-6.030 adds section (22), which incorporates 40 CFR 60 in whole by reference. It may be unnecessary to divert the public to another state regulation that incorporates a federal regulation by reference and provides no additional clarity than what is already specified in subparagraph (3)(D)1.A.

RESPONSE: The department appreciates this comment and for all air rules found in 10 CSR 10-Chapters 1-6, where stack testing methods or guidance documents are mentioned more than once, a reference to rule 10 CSR 10-6.030 was necessary to reduce the length of federal content incorporated by reference into these rules. As a result of this comment, no changes were made to the rule text.

COMMENT #11: The EPA encourages the department to assess the need for adding a reference to 10 CSR 10-6.030(22) in subparagraph (3)(D)1.B. because the subparagraph already specifies the CEMS must comply with the quality assurance procedures regardless of whether the installation is subject to New Source Performance Standards specified in 40 CFR 60, Appendix F. The draft rule text language for the potential revisions to 10 CSR 10-6.030 adds section (22), which incorporates 40 CFR 60 in whole by reference. It may be unnecessary to divert the public to another state regulation that incorporates a federal regulation by reference and provides no additional clarity than what is already specified in subparagraph (3)(D)1.B.

RESPONSE: The department appreciates this comment and for all air rules found in 10 CSR 10-Chapters 1-6, where stack testing methods or guidance documents are mentioned more than once, a reference to rule 10 CSR 10-6.030 reduces the length of federal content incorporated by reference into these rules. As a result of this comment, no changes were made to the rule text.

COMMENT #12: The EPA encourages the department to assess the need for adding a reference to 10 CSR 10-6.030(22) in paragraph (4)(A)1. because the paragraph already specifies the owner or operator must submit the "calculation and record keeping results" based upon correlations with ASTM and 40 CFR 60, Appendix A reference method results. The draft rule text language for the potential revisions to 10 CSR 10-6.030 adds section (22), which incorporates 40 CFR 60 in whole by reference. It may be unnecessary to divert the public to another state regulation that incorporates a federal regulation by reference and provides no additional clarity than what is already specified in paragraph (4)(A)1.

RESPONSE: The department appreciates this comment and for all air rules found in 10 CSR 10-Chapters 1-6, where stack testing methods or guidance documents are mentioned more than once, a reference to rule 10 CSR 10-6.030 was necessary to reduce the length of federal content incorporated by reference into these rules. As a result of this comment, no changes were made to the rule text.

COMMENT #13: The EPA encourages the department to assess the need for adding a reference to 10 CSR 10-6.030(22) in parts (4)(A)4.B.(I) or (4)(A)4.B.(II) because the parts already specify that—units maintaining a CEMS shall submit an excess emissions monitoring system performance report— in accordance with 40 CFR 60.7(c) and 40 CFR 60.13 (respectively). The draft rule text language for the potential revisions to 10 CSR 10-6.030 adds section (22), which incorporates 40 CFR 60 in whole by reference. It may be unnecessary to divert the public to another state regulation that incorporates a federal regulation by reference and provides no additional clarity than what is already specified in parts (4)(A)4.B.(I) or (4)(A)4.B.(II).

RESPONSE: The department appreciates this comment and for all air rules found in 10 CSR 10-Chapters 1-6, where stack testing methods or guidance documents are mentioned more than once, a reference to rule 10 CSR 10-6.030 reduces the length of federal content incorporated by reference into these rules. As a result of this comment, no changes were made to the rule text.

COMMENT #14: The EPA recommends the department reconsider removing the words "must be" from paragraphs (4)(B)12. and 13. Without "must be" the sentence—The twelve (12)-month rolling ton-nages [must be] made available upon request for inspector review no later than one (1) month following any calendar—is an incomplete sentence and may be confusing to the public. The EPA suggests "will be" as an alternative to striking the language completely.

RESPONSE AND EXPLANATION OF CHANGE: As a result of this comment, the terms "must be" will be replaced with "will be" in paragraphs (4)(B)12. and (4)(B)13.

COMMENT #15: The EPA recommends the department consider not limiting its incorporation by reference language of AP-42: EPA Compilation of Air Emissions Factors in subsection (5)(D) to those versions "published by January 1995 and August 1995." Many chapters of AP-42 have been updated since 1995 and this incorporation makes it unclear if those chapters can be used to report emissions.

RESPONSE AND EXPLANATION OF CHANGE: In subsection (5)(D), the AP-42 and Factor Information and Retrieval System (FIRE) referenced documents are generally used and obtained from the current electronic version on EPA's internet site. Missouri statute 536.031.4., RSMo, requires that the department "shall maintain a copy of the referenced rule, regulation, standard, or guideline at the headquarters of the agency and shall make it available to the public for inspection and copying at no more than the actual cost of reproduction." The most updated full version containing all the chapters of AP-42 and FIRE in PDF format were published on the January 1995 and August 1995 dates. Chapters in AP-42 and FIRE are continually being revised and the department has determined that the latest updates for all chapters in AP-42 and FIRE will be used as the incorporation by reference dates. Copies will be retained by the department as required by statute. As a result of this comment, the publishing dates in subsection (5)(D) will be adjusted to August 2018 and August 2017 to account for the latest approved versions of AP-42 and FIRE, and the terms "as updated" will be removed to avoid confusion.

COMMENT #16: The EPA recommends the department reconsider adding the sentence in subsection (5)(D), "This rule does not incorporate any subsequent amendments or additions" as it appears to preclude the use of emission factors published since 1995.

RESPONSE AND EXPLANATION OF CHANGE: In subsection (5)(D), the AP-42 and FIRE referenced documents are generally used and obtained from the current electronic version on EPA's internet site. Missouri statute 536.031.4., RSMo, requires that the department "shall maintain a copy of the referenced rule, regulation, standard, or guideline at the headquarters of the agency and shall make it available to the public for inspection and copying at no more than the actual cost of reproduction." The most updated full version containing all the chapters of AP-42 and FIRE in PDF format were

published on the January 1995 and August 1995 dates. Chapters in AP-42 and FIRE are continually being revised and the department has determined that the latest updates for all chapters in AP-42 and FIRE will be used as the incorporation by reference dates. As a result of this comment, the publishing dates in subsection (5)(D) will be adjusted to August 2018 and August 2017 to account for the latest approved versions of AP-42 and FIRE, and the terms “as updated” will be removed to avoid confusion.

10 CSR 10-5.570 Control of Sulfur Emissions From Stationary Boilers

(2) Definitions.

(C) Gaseous fuel—A combustible gas that includes, but is not limited to, natural gas, landfill gas, coal-derived gas, refinery gas, and biogas. Blast furnace gas is not considered a gaseous fuel under this definition.

(4) Reporting and Record Keeping.

(B) Record Keeping Requirements. The owner or operator subject to this rule shall maintain all records necessary to demonstrate compliance with this rule for a period of five (5) years at the plant at which the unit is located. Daily records, along with the twelve (12)-month rolling tonnage or twelve (12)-month rolling average, shall be made available no later than one (1) month following any calendar month. The records shall be made available to the director upon request. The owner or operator shall maintain records of the following information for each month the unit is operated:

1. The identification number of each unit and the name and address of the plant where the unit is located for each unit subject to this rule;
2. The calendar date of record;
3. The number of hours the unit is operated each day including start-ups, shutdowns, malfunctions, and the type and duration of maintenance and repair;
4. The date and results of each emissions inspection;
5. A summary of any emissions corrective maintenance taken;
6. The results of all compliance tests;
7. If a unit is equipped with a CEMS—
 - A. The identification of time periods during which SO₂ standards are exceeded, the reason for exceedance, and action taken to correct the exceedance and prevent similar future exceedances; and
 - B. The identification of the time periods for which operating conditions and pollutant data were not obtained, including reasons for not obtaining sufficient data, and a description of corrective actions taken;
8. The total heat input for each fuel used per emissions unit on a monthly basis;
9. The amount of each fuel consumed per emissions unit on a monthly basis;
10. The average heat content for each fuel used per emissions unit on a monthly basis;
11. The average percent sulfur for each fuel used per emissions unit on a monthly basis;
12. The emission rate in lbs per mmBtu for each unit on a monthly basis for those units complying with the limit in paragraph (3)(A)1. of this rule. The twelve (12)-month rolling averages will be made available upon request for the inspector to review no later than one (1) month following any calendar month;
13. The monthly emission rate in tons SO₂ for those units complying with the limit in paragraph (3)(A)2. of this rule. The twelve (12)-month rolling tonnages will be made available upon request for inspector review no later than one (1) month following any calendar month; and
14. Any other reports deemed necessary by the director.

(5) Test Methods. The following hierarchy of methods shall be used to determine if a unit qualifies for the low-emitter exemption in para-

graph (1)(C)4. of this rule. If data is not available for an emission estimation method or an emission estimation method is impractical for a source, then the subsequent emission estimation method shall be used in its place:

(D) AP-42 (EPA *Compilation of Air Pollution Emission Factors*) or FIRE (Factor Information and Retrieval System) as published by EPA August 2018 and August 2017 and hereby incorporated by reference in this rule. Copies can be obtained from the National Technical Information Service (NTIS), 5285 Port Royal Road, Springfield VA 22161. This rule does not incorporate any subsequent amendments or additions;

Title 10—DEPARTMENT OF NATURAL RESOURCES Division 10—Air Conservation Commission Chapter 6—Air Quality Standards, Definitions, Sampling and Reference Methods and Air Pollution Control Regulations for the Entire State of Missouri

ORDER OF RULEMAKING

By the authority vested in the Missouri Air Conservation Commission under section 643.050, RSMo 2016, the commission amends a rule as follows:

10 CSR 10-6.030 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on May 15, 2018 (43 MoReg 1024–1026). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources’ Air Pollution Control Program received eight (8) comments on this rulemaking from the U.S. Environmental Protection Agency (EPA).

Due to similar concerns expressed in the following five (5) comments, one (1) response that addresses these concerns is at the end of these five (5) comments.

COMMENT #1: The EPA provided a general comment for all the rules that the department has the responsibility to ensure that the State Implementation Plan (SIP) revision submitted to EPA meets the requirements of Sections 110(1) and 193 of the Clean Air Act (CAA).

Section 110(1): Generally, section 110(1) provides that EPA cannot approve a SIP revision if the revision interferes with any applicable requirement concerning attainment and reasonable further progress or any other requirement of the CAA. This section applies to any area and to any National Ambient Air Quality Standard (NAAQS) pollutant and/or precursor. Thus, any SIP rule is subject to this section.

Section 193: Section 193 prohibits modification of a SIP in effect before 1990 unless that modification would ensure equivalent or greater emissions reductions, i.e., “anti-backsliding.” Section 193 applies only to nonattainment areas and is specific to the nonattainment pollutant. The applicability of section 193 is specific to nonattainment “criteria” pollutants. The ozone implementation rule (codified at 40 CFR 51.905(a)(4)), describes how section 193 applies to Kansas City - an attainment area for the eight (8)-hour standard and maintenance area for the one (1)-hour standard.

Each of the eleven (11) proposed rule rescissions are subject to section 110(1) requirements; six (6) of the proposed rule rescissions are subject to the section 193 requirements. One (1) of the seven (7) proposed rule revisions is subject to section 110(1) requirements, one (1) is a Title V Part 70 revision, one (1) is a 111(d) plan revision, and the remaining four (4) proposed rule revisions are administrative

in nature only.

COMMENT #2: The EPA suggests a demonstration that quantifies any emissions increase or potential increase by rescinding the rule(s), and a discussion on the impact on air quality. This demonstration could be done by comparing the source inventory at the time the rule was promulgated to the source inventory now, and demonstrating the overall impact on emissions. In addition, the department could include a discussion of the monitored air quality when the rule was promulgated/incorporated into the SIP and monitored air quality trends that demonstrate an improvement in air quality and how the rescission of the rule might impact those trends.

COMMENT #3: The EPA suggests a discussion of the rule's purpose; specifically, whether the rule was promulgated to meet nonattainment area requirements, and if so, which specific NAAQS. In addition, the department could describe how the rule no longer serves to meet that purpose or how the rule has been superseded by another permanent and enforceable mechanism.

COMMENT #4: The EPA suggests a discussion of whether the rule was used to support other actions and whether the removal of the rule would impact those obligations such as an attainment demonstration, a request for a determination to attainment, a redesignation request and maintenance plan, or other actions such as Regional Haze or Interstate Transport.

COMMENT #5: The EPA suggests that where the department may be anticipating other federal programs, such as Maximum Achievable Control Technology and National Emissions Standards for Hazardous Air Pollutants, as acting as a backstop to removal of its Reasonably Available Control Technology (RACT) rules, a comprehensive discussion of how those programs equal RACT. For example, there may be volatile organic compound (VOC) sources regulated by these programs that are well-controlled through add-on controls, or even through substitution of non-hazardous air pollutant material for VOC hazardous air pollutant materials, however, these programs only cover air toxics and not all VOC emissions that RACT would capture and control are air toxics.

RESPONSE: The amendment of the rule is consistent with Executive Order 17-03 requiring a review of every regulation to affirm that the regulation is essential to the health, safety, or welfare of Missouri residents. Emissions will not increase with the proposed rule amendment and the revision will meet CAA sections 110(l) and 193 requirements. There is no negative impact on air quality. The department is not anticipating the use of other federal programs as a backstop because the department is not rescinding this rule. No changes were made to the rule text as a result of this comment.

COMMENT #6: The EPA encourages the department to assess the need for adding a reference to sections (21), (22), and (23) in sections (1) to (17) of the rule because sections (1) to (17) already specify the applicable test methods and where to find them in 40 CFR 51, Appendix M; 40 CFR 60, Appendix A; or 40 CFR 61, Appendix A, respectively. The draft rule text language for the proposed revisions to 10 CSR 10-6.030 adds sections (21), (22), and (23), which incorporate 40 CFR 51, 60, and 61 (respectively), in whole, by reference. It may be unnecessary to divert the public to another section of the same Missouri Air Conservation Commission (MACC) regulation that incorporates a federal regulation by reference and provides no additional clarity than what is already specified in sections (1) to (17).

RESPONSE: The department appreciates this comment and for all air rules found in 10 CSR 10 Chapters 1-6, where stack testing methods or guidance documents are mentioned more than once, a reference to rule 10 CSR 10-6.030 reduces the length of federal content incorporated by reference into these rules. When all rules have been revised to the new method of incorporating by references, sections (1) through (20) will no longer be in use. As a result of this comment, no rule text changes have been made.

COMMENT #7: The EPA recommends that the department consider their incorporations by reference of 40 CFR 51, 60, and 61 in whole

in sections (21), (22), and (23) of the rule. Incorporating whole parts of the *Code of Federal Regulations* like 40 CFR 51, 60, and 61 would be unusual, where the department already selectively incorporates individual technology standards in 10 CSR 10-6.070 and 6.080. The EPA recommends, if the department intends to continue to incorporate requirements of the code of federal regulations by reference, that the incorporations be very specific. Because the title of 10 CSR 10-6.030 is Sampling Methods for Air Pollution Sources, EPA recommends that the department consider incorporating by reference only the sampling method related requirements of 40 CFR 51, 60, and 61 into the MACC rule. For example, the department could incorporate by reference Appendix M to part 51-Recommended Test Methods for State Implementation Plans, Appendix A to part 60-Test Methods or Appendix B to part 61-Test Methods.

RESPONSE AND EXPLANATION OF CHANGE: As a result of this comment, rather than incorporating by reference 40 CFR 51, 60, and 61 in whole, rule text in sections (21), (22), and (23) has been revised to incorporate by reference specific appendices and subparts.

COMMENT #8: If the department's intention is to expand the scope of this rule to include all incorporation by reference materials, then it may also want to consider changing the title of this rule.

RESPONSE: One (1) of the aims of the proposed amendments to this rule is to reduce the amount of federal content incorporated by reference into all 10 CSR 10 chapters 1-6. Where stack testing methods or guidance documents in other 10 CSR 10-chapters 1-6 rules are mentioned only once, a reference is not made to 10 CSR 10-6.030 and those documents are incorporated by reference in their respective rules. The department plans to retain the title of this rule because all information in other rules are not incorporated by reference in 10 CSR 10-6.030. As a result of this comment, no rule text changes have been made.

10 CSR 10-6.030 Sampling Methods for Air Pollution Sources

(21) 40 CFR 51, Appendices M, and W, and Subparts A, G, I, T, and W promulgated as of July 1, 2018 are hereby incorporated by reference in this rule, as published by the Office of the Federal Register. Copies can be obtained from the U.S. Publishing Office Bookstore, 710 N. Capitol Street NW, Washington, DC 20401. This rule does not incorporate any subsequent amendments or additions.

(22) 40 CFR 60, Appendices A, B, E, and F, and Subparts A, B, Cb, Cf, XXX, DDDD, MMMM, and RRRR promulgated as of July 1, 2018 are hereby incorporated by reference in this rule, as published by the Office of the Federal Register. Copies can be obtained from the U.S. Publishing Office Bookstore, 710 N. Capitol Street NW, Washington, DC 20401. This rule does not incorporate any subsequent amendments or additions.

(23) 40 CFR 61, Appendix B promulgated as of July 1, 2018 are hereby incorporated by reference in this rule, as published by the Office of the Federal Register. Copies can be obtained from the U.S. Publishing Office Bookstore, 710 N. Capitol Street NW, Washington, DC 20401. This rule does not incorporate any subsequent amendments or additions.

Title 10—DEPARTMENT OF NATURAL RESOURCES Division 10—Air Conservation Commission Chapter 6—Air Quality Standards, Definitions, Sampling and Reference Methods and Air Pollution Control Regulations for the Entire State of Missouri

ORDER OF RULEMAKING

By the authority vested in the Missouri Air Conservation Commission under section 643.050, RSMo 2016, the commission

amends a rule as follows:

10 CSR 10-6.040 Reference Methods is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on May 15, 2018 (43 MoReg 1026-1029). No changes were made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Air Pollution Control Program received five (5) comments on this rulemaking from the U.S. Environmental Protection Agency (EPA).

Due to similar concerns expressed in the following five (5) comments, one (1) response that addresses these concerns is at the end of these five (5) comments.

COMMENT #1: The EPA provided a general comment for all the rules that the department has the responsibility to ensure that the State Implementation Plan (SIP) revision submitted to EPA meets the requirements of Sections 110(1) and 193 of the Clean Air Act (CAA).

Section 110(1): Generally, section 110(1) provides that EPA cannot approve a SIP revision if the revision interferes with any applicable requirement concerning attainment and reasonable further progress or any other requirement of the CAA. This section applies to any area and to any National Ambient Air Quality Standard (NAAQS) pollutant and/or precursor. Thus, any SIP rule is subject to this section.

Section 193: Section 193 prohibits modification of a SIP in effect before 1990 unless that modification would ensure equivalent or greater emissions reductions, i.e., "anti-backsliding." Section 193 applies only to nonattainment areas and is specific to the nonattainment pollutant. The applicability of section 193 is specific to nonattainment "criteria" pollutants. The ozone implementation rule (codified at 40 CFR 51.905(a)(4)), describes how section 193 applies to Kansas City - an attainment area for the eight (8)-hour standard and maintenance area for the one (1)-hour standard.

Each of the eleven (11) proposed rule rescissions are subject to section 110(1) requirements; six (6) of the proposed rule rescissions are subject to the section 193 requirements. One (1) of the seven (7) proposed rule revisions is subject to section 110(1) requirements, one (1) is a Title V Part 70 revision, one (1) is a 111(d) plan revision, and the remaining four (4) proposed rule revisions are administrative in nature only.

COMMENT #2: The EPA suggests a demonstration that quantifies any emissions increase or potential increase by rescinding the rule(s), and a discussion on the impact on air quality. This demonstration could be done by comparing the source inventory at the time the rule was promulgated to the source inventory now, and demonstrating the overall impact on emissions. In addition, the department could include a discussion of the monitored air quality when the rule was promulgated/incorporated into the SIP and monitored air quality trends that demonstrate an improvement in air quality and how the rescission of the rule might impact those trends.

COMMENT #3: The EPA suggests a discussion of the rule's purpose; specifically, whether the rule was promulgated to meet nonattainment area requirements, and if so, which specific NAAQS. In addition, the department could describe how the rule no longer serves to meet that purpose or how the rule has been superseded by another permanent and enforceable mechanism.

COMMENT #4: The EPA suggests a discussion of whether the rule was used to support other actions and whether the removal of the rule would impact those obligations such as an attainment demonstration, a request for a determination to attainment, a redesignation request and maintenance plan, or other actions such as Regional Haze or Interstate Transport.

COMMENT #5: The EPA suggests that where the department may be anticipating other federal programs, such as Maximum Achievable Control Technology and National Emissions Standards for Hazardous Air Pollutants, as acting as a backstop to removal of its Reasonably Available Control Technology (RACT) rules, a comprehensive discussion of how those programs equal RACT. For example, there may be volatile organic compound (VOC) sources regulated by these programs that are well-controlled through add-on controls, or even through substitution of non-hazardous air pollutant material for VOC hazardous air pollutant materials, however, these programs only cover air toxics and not all VOC emissions that RACT would capture and control are air toxics.

RESPONSE: The amendment of the rule is consistent with Executive Order 17-03 requiring a review of every regulation to affirm that the regulation is essential to the health, safety, or welfare of Missouri residents. Emissions will not increase with the proposed rule amendment and the revision will meet CAA sections 110(l) and 193 requirements. There is no negative impact on air quality. The department is not anticipating the use of other federal programs as a backstop because the department is not rescinding this rule. No changes were made to the rule text as a result of this comment.

**Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 6—Air Quality Standards, Definitions,
Sampling and Reference Methods and Air Pollution
Control Regulations for the Entire State of Missouri**

ORDER OF RULEMAKING

By the authority vested in the Missouri Air Conservation Commission under section 643.050, RSMo 2016, the commission amends a rule as follows:

10 CSR 10-6.110 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on May 15, 2018 (43 MoReg 1029-1032). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Air Pollution Control Program received a total of nine (9) comments on this rulemaking. Eight (8) comments on this rulemaking were from the U.S. Environmental Protection Agency (EPA) and one (1) comment was from Liberty Utilities/Empire District.

Due to similar concerns expressed in the following five (5) comments, one (1) response that addresses these concerns is at the end of these five (5) comments.

COMMENT #1: The EPA provided a general comment for all the rules that the department has the responsibility to ensure that the State Implementation Plan (SIP) revision submitted to EPA meets the requirements of Sections 110(1) and 193 of the Clean Air Act (CAA).

Section 110(1): Generally, section 110(1) provides that EPA cannot approve a SIP revision if the revision interferes with any applicable requirement concerning attainment and reasonable further progress or any other requirement of the CAA. This section applies to any area and to any National Ambient Air Quality Standard (NAAQS) pollutant and/or precursor. Thus, any SIP rule is subject to this section.

Section 193: Section 193 prohibits modification of a SIP in effect before 1990 unless that modification would ensure equivalent or greater emissions reductions, i.e., "anti-backsliding." Section 193 applies only to nonattainment areas and is specific to the nonattainment pollutant.

The applicability of section 193 is specific to nonattainment “criteria” pollutants. The ozone implementation rule (codified at 40 CFR 51.905(a)(4)), describes how section 193 applies to Kansas City - an attainment area for the eight (8)-hour standard and maintenance area for the one (1)-hour standard.

Each of the eleven (11) proposed rule rescissions are subject to section 110(1) requirements; six (6) of the proposed rule rescissions are subject to the section 193 requirements. One (1) of the seven (7) proposed rule revisions is subject to section 110(1) requirements, one (1) is a Title V Part 70 revision, one (1) is a 111(d) plan revision, and the remaining four (4) proposed rule revisions are administrative in nature only.

COMMENT #2: The EPA suggests a demonstration that quantifies any emissions increase or potential increase by rescinding the rule(s), and a discussion on the impact on air quality. This demonstration could be done by comparing the source inventory at the time the rule was promulgated to the source inventory now, and demonstrating the overall impact on emissions. In addition, the department could include a discussion of the monitored air quality when the rule was promulgated/incorporated into the SIP and monitored air quality trends that demonstrate an improvement in air quality and how the rescission of the rule might impact those trends.

COMMENT #3: The EPA suggests a discussion of the rule’s purpose; specifically, whether the rule was promulgated to meet nonattainment area requirements, and if so, which specific NAAQS. In addition, the department could describe how the rule no longer serves to meet that purpose or how the rule has been superseded by another permanent and enforceable mechanism.

COMMENT #4: The EPA suggests a discussion of whether the rule was used to support other actions and whether the removal of the rule would impact those obligations such as an attainment demonstration, a request for a determination to attainment, a redesignation request and maintenance plan, or other actions such as Regional Haze or Interstate Transport.

COMMENT #5: The EPA suggests that where the department may be anticipating other federal programs, such as Maximum Achievable Control Technology and National Emissions Standards for Hazardous Air Pollutants, as acting as a backstop to removal of its Reasonably Available Control Technology (RACT) rules, a comprehensive discussion of how those programs equal RACT. For example, there may be volatile organic compound (VOC) sources regulated by these programs that are well-controlled through add-on controls, or even through substitution of non-hazardous air pollutant material for VOC hazardous air pollutant materials, however, these programs only cover air toxics and not all VOC emissions that RACT would capture and control are air toxics.

RESPONSE: The amendment of the rule is consistent with Executive Order 17-03 requiring a review of every regulation to affirm that the regulation is essential to the health, safety, or welfare of Missouri residents. Emissions will not increase with the proposed rule amendment and the revision will meet CAA sections 110(l) and 193 requirements. There is no negative impact on air quality. The department is not anticipating the use of other federal programs as a backstop because the department is not rescinding this rule. No changes were made to the rule text as a result of this comment.

COMMENT #6: The EPA recommends that the department consider the date cited in subparagraph (3)(C)4.B. This subsection incorporates 40 CFR 51.21 by reference as of July 1, 2017, however, the Code of Federal Regulations (CFR) is traditionally updated as of July 1 of each year. The EPA recommends the reference date “as of July 1, 2018.”

RESPONSE AND EXPLANATION OF CHANGE: As a result of this comment, subparagraph (3)(C)4.B. was updated to include the most recent updates to the CFR.

COMMENT #7: The EPA recommends that the department consider not limiting its incorporation by reference language of AP-42: EPA Compilation of Air Emissions Factors in subparagraph (3)(B)1.D. to

those versions “published by January 1995 and August 1995.” Many chapters of AP-42 have been updated since 1995 and this incorporation makes it unclear if those chapters can be used to report emissions.

RESPONSE AND EXPLANATION OF CHANGE: In subparagraph (3)(B)1.D., the AP-42 and Factor Information and Retrieval System (FIRE) referenced documents are generally used and obtained from the current electronic version on EPA’s internet site. Missouri statute 536.031.4., RSMo, requires that the department “shall maintain a copy of the referenced rule, regulation, standard, or guideline at the headquarters of the agency and shall make it available to the public for inspection and copying at no more than the actual cost of reproduction.” The most updated full version containing all the chapters of AP-42 and FIRE in PDF format were published on the January 1995 and August 1995 dates. Chapters in AP-42 and FIRE are continually being revised and the department has determined that the latest updates for all chapters in AP-42, and FIRE will be used as the incorporation by reference dates. Copies will be retained by the department as required by statute. As a result of this comment, the publishing dates in subparagraph (3)(B)1.D. will be adjusted to August 2018 and August 2017 to account for the latest approved versions of AP-42 and FIRE, and the terms “as updated” will be removed to avoid confusion.

COMMENT #8: The EPA recommends that the department reconsider adding the sentence in subparagraph (3)(B)1.D., “This rule does not incorporate any subsequent amendments or additions” as it appears to preclude the use of emission factors published since 1995.

RESPONSE AND EXPLANATION OF CHANGE: In subparagraph (3)(B)1.D., the AP-42 and FIRE referenced documents are generally used and obtained from the current electronic version on EPA’s internet site. Missouri statute 536.031.4., RSMo, requires that the department “shall maintain a copy of the referenced rule, regulation, standard, or guideline at the headquarters of the agency and shall make it available to the public for inspection and copying at no more than the actual cost of reproduction.” The most updated full version containing all the chapters of AP-42 and FIRE in PDF format were published on the January 1995 and August 1995 dates. Chapters in AP-42 and FIRE are continually being revised and the department has determined that the latest updates for all chapters in AP-42, and FIRE will be used as the incorporation by reference dates. Copies will be retained by the department as required by statute. As a result of this comment, the publishing dates in subparagraph (3)(B)1.D. will be adjusted to August 2018 and August 2017 to account for the latest approved versions of AP-42 and FIRE, and the terms “as updated” will be removed to avoid confusion.

COMMENT #9: In the General Provisions section, paragraph (3)(A)1.—Why is the forty-eight dollars (\$48.00) per ton effective date January 1, 2019 and not 2017? The way this reads indicates that sources will have overpaid fees for 2017 and 2018.

RESPONSE AND EXPLANATION OF CHANGE: This amendment is not intended to change the effective date for the fee. As a result of this comment, the last sentence in paragraph (3)(A)1. was revised for clarification.

10 CSR 10-6.110 Reporting Emission Data, Emission Fees, and Process Information

(3) General Provisions.

(A) Emission Fees.

1. Any installation subject to this rule, except sources that produce charcoal from wood, shall pay an annual emission fee per ton of applicable pollutant emissions identified in Table 2 of this rule based on previous calendar year emissions and in accordance with paragraphs (3)(A)2. through (3)(A)7. of this rule. The emission fee shall be forty-eight dollars and no cents (\$48.00) per ton.

2. For Full Emissions Reports, the fee is based on the information provided in the installation’s emissions report. For sources

which qualify for and use the Reduced Reporting Form, the fee shall be based on the last Full Emissions Report.

3. The fee shall apply to the first four thousand (4,000) tons of each air pollutant subject to fees as identified in Table 2 of this rule. No installation shall be required to pay fees on total emissions in excess of twelve thousand (12,000) tons for any reporting year. An installation subject to this rule which emitted less than one (1) ton of all pollutants subject to fees shall pay a fee for one (1) ton.

4. An installation which pays emission fees to a holder of a certificate of authority issued pursuant to section 643.140, RSMo, may deduct those fees from the emission fee due under this section.

5. The fee imposed in paragraph (3)(A)1. of this rule shall not apply to NH₃, CO, PM_{2.5}, or HAPs reported as PM₁₀ or VOC, as summarized in Table 2 of this rule.

6. Emission fees for the reporting year are due June 1 after each reporting year. The fees shall be payable to the Missouri Department of Natural Resources.

7. To determine emission fees, an installation shall be considered one (1) source as defined in section 643.078.2, RSMo, except that an installation with multiple operating permits shall pay emission fees separately for air pollutants emitted under each individual permit.

TABLE 2. Pollutant Fee Applicability

Pollutants Subject to Fees	Pollutants Not Subject to Fees
PM ₁₀ pri	PM _{2.5} pri
SO ₂	CO
NO _x	NH ₃
VOC	HAPs reported as PM ₁₀ or VOC
HAP	
Lead	

(B) Emission Estimation Calculation and Verification.

1. The method of determining an emission factor, capture efficiency, or control efficiency for use in the emissions report shall be consistent with the installation's applicable permit. Variance from this method shall be based on the hierarchy described below. If data is not available for an emission estimation method or an emission estimation method is impractical for a source, then the subsequent emission estimation method shall be used in its place—

A. Continuous Emission Monitoring System (CEMS) as specified in subparagraph (3)(B)2.A. of this rule;

B. Stack tests as specified in subparagraph (3)(B)2.B. of this rule;

C. Material/mass balance;

D. AP-42 (Environmental Protection Agency (EPA) *Compilation of Air Pollution Emission Factors*) or FIRE (Factor Information and Retrieval System) as published by EPA August 2018 and August 2017, respectively, and hereby incorporated by reference in this rule. Copies can be obtained from the National Technical Information Service (NTIS), 5285 Port Royal Road, Springfield, VA 22161. This rule does not incorporate any subsequent amendments or additions;

E. Other EPA documents as specified in subparagraph (3)(B)2.C. of this rule;

F. Sound engineering or technical calculations; or

G. Facilities shall obtain department approval of emission estimation methods other than those listed in subparagraphs (3)(B)1.A.–F. of this rule before using any such method to estimate emissions in the submission of an emissions report.

2. The director reserves the authority to review and approve all

emission estimation methods used to calculate emissions for the purpose of filing an emissions report for accuracy, reliability, and appropriateness. Inappropriate usage of an emission factor or method shall include, but is not limited to: varying from the method used in permit without prior approval, using emission factors not representative of a process, using equipment in a manner other than that for which it was designed for in calculating emissions, or using a less accurate emission estimation method for a process when a facility has more accurate emission data available. Additional requirements for the use of a specific emission estimation method include:

A. Continuous Emission Monitoring System (CEMS).

(I) CEMS must be shown to have met applicable performance specifications during the period for which data is being presented.

(II) CEMS data must be presented in the units which the system was designed to measure. Additional data sets used to extrapolate CEMS data must have equal or better reliability for such extrapolation to be acceptable.

(III) When using CEMS data to estimate emissions, the data must include all parameters (i.e., emission rate, gas flow rate, etc.) necessary to accurately determine the emissions. CEMS data which does not include all the necessary parameters must be reviewed and approved by the director or local air pollution control authority before it may be used to estimate emissions;

B. Stack tests.

(I) Stack tests must be conducted on the specific equipment for which the stack test results are used to estimate emissions.

(II) Stack tests must be conducted according to the methods cited in 10 CSR 10-6.030, unless an alternative method has been approved in advance by the director or local air pollution control authority.

(III) Stack tests will not be accepted unless the choice of test sites and a detailed test plan have been approved in advance by the director or local air pollution control authority.

(IV) Stack tests will not be accepted unless the director or local air pollution control authority has been notified of test dates at least thirty (30) days in advance and thus provided the opportunity to observe the testing. This thirty (30)-day notification may be reduced or waived on a case-by-case basis by the director or local air pollution control authority.

(V) Stack test results which do not meet all the criteria of parts (3)(B)2.B.(I)–(IV) of this rule may be acceptable for estimating emissions but must be submitted for review and approval by the director or local air pollution control authority on a case-by-case basis; and

C. Other EPA documents may be used to estimate emissions if the emission factors are more appropriate or source specific than AP-42 or FIRE. Newly developed EPA emission factors must be published by December 31 of the year for which the facility is submitting an emissions report.

(C) Emission Data and Fee Auditing and Adjustment.

1. The department may conduct detailed audits of emissions reports and supporting documentation as the director deems necessary. A minimum seven (7)-day notice must be provided to the installation to prepare documentation if this audit is done on-site.

2. The department may make emission fee adjustments when any of the following applies—

A. Clerical or arithmetic errors have been made;

B. Submitted documentation is not supported by inspections or audits;

C. Emissions estimates are modified as a result of emission verification or audits;

D. Credit has been incorrectly applied for an emissions fee paid to a local air pollution control agency; or

E. Emission estimation calculation varies from the methods described in subsection (3)(B) of this rule.

3. The department is not limited by subparagraphs (3)(C)2.A.–E. of this rule in making emission fee adjustments.

4. Adjustments to data and fees will be subject to a three (3)-year statute of limitations unless it is—

A. Due to a willful failure to report emissions or fraudulent representation for which there shall be no statute of limitations; or

B. Adjustment of emissions is based on a permitting action under 40 CFR 52.21 for which an adjustment of fees is required to all years of emission data changed up to a maximum of ten (10) years. 40 CFR 52.21 was promulgated as of July 1, 2018 and is hereby incorporated by reference as published by the Office of the Federal Register. Copies can be obtained from the U.S. Publishing Office Bookstore, 710 N. Capitol Street NW, Washington, DC 20401. This rule does not incorporate any subsequent amendments or additions. If approved, fees in effect at the time will be due, but no credit will be applied at the emission unit level.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 6—Air Quality Standards, Definitions,
Sampling and Reference Methods and Air Pollution
Control Regulations for the Entire State of Missouri

ORDER OF RULEMAKING

By the authority vested in the Missouri Air Conservation Commission under section 643.050, RSMo 2016, the commission amends a rule as follows:

10 CSR 10-6.200 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on May 15, 2018 (43 MoReg 1032-1046). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Air Pollution Control Program received nine (9) comments from the U.S. Environmental Protection Agency (EPA) and one (1) comment from Department staff.

Due to similar concerns expressed in the following five (5) comments, one (1) response that addresses these concerns is at the end of these five (5) comments.

COMMENT #1: The EPA provided a general comment for all the rules that the department has the responsibility to ensure that the State Implementation Plan (SIP) revision submitted to EPA meets the requirements of sections 110(1) and 193 of the Clean Air Act (CAA).

Section 110(1): Generally, Section 110(1) provides that EPA cannot approve a SIP revision if the revision interferes with any applicable requirement concerning attainment and reasonable further progress or any other requirement of the CAA. This section applies to any area and to any National Ambient Air Quality Standard (NAAQS) pollutant and/or precursor. Thus, any SIP rule is subject to this section.

Section 193: Section 193 prohibits modification of a SIP in effect before 1990 unless that modification would ensure equivalent or greater emissions reductions, i.e., "anti-backsliding." Section 193 applies only to nonattainment areas and is specific to the nonattainment pollutant. The applicability of section 193 is specific to nonattainment "criteria" pollutants. The ozone implementation rule (codified at 40 CFR 51.905(a)(4)), describes how section 193 applies to Kansas City - an attainment area for the eight (8)-hour standard and maintenance area for the one (1)-hour standard.

Each of the eleven (11) proposed rule rescissions are subject to section 110(1) requirements; six (6) of the proposed rule rescissions are subject to the section 193 requirements. One (1) of the seven (7)

proposed rule revisions is subject to section 110(1) requirements, one (1) is a Title V Part 70 revision, one (1) is a 111(d) plan revision, and the remaining four (4) proposed rule revisions are administrative in nature only.

COMMENT #2: The EPA suggests a demonstration that quantifies any emissions increase or potential increase by rescinding the rule(s), and a discussion on the impact on air quality. This demonstration could be done by comparing the source inventory at the time the rule was promulgated to the source inventory now, and demonstrating the overall impact on emissions. In addition, the department could include a discussion of the monitored air quality when the rule was promulgated/incorporated into the SIP and monitored air quality trends that demonstrate an improvement in air quality and how the rescission of the rule might impact those trends.

COMMENT #3: The EPA suggests a discussion of the rule's purpose; specifically, whether the rule was promulgated to meet nonattainment area requirements, and if so, which specific NAAQS. In addition, the department could describe how the rule no longer serves to meet that purpose or how the rule has been superseded by another permanent and enforceable mechanism.

COMMENT #4: The EPA suggests a discussion of whether the rule was used to support other actions and whether the removal of the rule would impact those obligations such as an attainment demonstration, a request for a determination to attainment, a redesignation request and maintenance plan, or other actions such as Regional Haze or Interstate Transport.

COMMENT #5: The EPA suggests that where the department may be anticipating other federal programs, such as Maximum Achievable Control Technology and National Emissions Standards for Hazardous Air Pollutants, as acting as a backstop to removal of its Reasonably Available Control Technology (RACT) rules, a comprehensive discussion of how those programs equal RACT. For example, there may be volatile organic compound (VOC) sources regulated by these programs that are well-controlled through add-on controls, or even through substitution of non-hazardous air pollutant material for VOC hazardous air pollutant materials, however, these programs only cover air toxics and not all VOC emissions that RACT would capture and control are air toxics.

RESPONSE: The amendment of the rule is consistent with Executive Order 17-03 requiring a review of every regulation to affirm that the regulation is essential to the health, safety, or welfare of Missouri residents. Emissions will not increase with the proposed rule amendment and the revision will meet CAA section 111(d) plan requirements. There is no negative impact on air quality. The department is not anticipating the use of other federal programs as a backstop because the department is not rescinding this rule. No changes were made to the rule text as a result of this comment.

COMMENT #6: The EPA encourages the department to assess the need for the rule in general. The Rulemaking Report says that "the purpose of the proposed rulemaking is to incorporate by reference the federal regulatory requirements for existing hospital, medical, and infectious waste incinerators of 40 CFR 60 Subpart Ce-Emission Guidelines and Compliance Times for Hospital/Medical/Infectious Waste Incinerators." The hospital, medical, and infectious waste incinerator (HMIWI) emission guidelines at 40 CFR subpart Ce apply to existing sources for which construction was commenced on or before June 20, 1996, or for which modification was commenced on or before March 16, 1998, or for which construction was commenced after June 20, 1996, but no later than December 1, 2008, or for which modification is commenced after March 16, 1998, but no later than April 6, 2010. It is our understanding, given the applicability dates noted above, that the department currently does not regulate an existing source subject to the HMIWI, and it is unlikely that the department will regulate a new "existing" source. New sources subject to HMIWI regulations would be subject to the requirements of 40 CFR 60, subpart Ee.

RESPONSE: Missouri has hospitals that have older incinerators located at their facility. While these incinerators may not be operating

at this time, they could be returned to service in the future. This rule is necessary until those older incinerators are permanently removed from service. No change was made to the rule text as a result of this comment.

Due to similar concerns expressed in the following two (2) comments, one (1) response that addresses these concerns is at the end of these two (2) comments.

COMMENT #7: The EPA encourages the department to assess the need for adding a reference to 10 CSR 10-6.030(22) in section (2), Definitions, because the subsection already specifies that applicable definitions can be found at 40 CFR 60.31e. The draft rule text language for the potential revisions to 10 CSR 10-6.030 Sampling Methods, adds section (22), which incorporates 40 CFR 60 in whole by reference. It may be unnecessary to divert the public to another state regulation that incorporates a federal regulation by reference and provides no additional clarity than what is already specified in section (2).

COMMENT #8: The EPA encourages the department to assess the need for adding 10 CSR 10-6.030(22) in section (3), General Provisions. The proposed rule revision text says, "The following references to 40 CFR 60.33e through 60.37e and 40 CFR 60 Subpart Ce Tables 1A through 2B apply as specified in 10 CSR 10-6.030(22)," however the draft rule text language for the potential revisions to 10 CSR 10-6.030, Sampling Methods, adds section (22) incorporates 40 CFR 60 in whole by reference and does not provide any specific information about the rules referenced. It may be unnecessary to divert the public to another state regulation that incorporates a federal regulation by reference and provides no additional clarity than what is already specified in section (3).

RESPONSE: The department appreciates this comment and for all air rules found in 10 CSR 10 Chapters 1-6, where stack testing methods or guidance documents are mentioned, a reference to rule 10 CSR 10-6.030 reduces the length of federal content incorporated by reference into these rules. No change was made to the rule text as a result of this comment.

COMMENT #9: The EPA recommends, if the department intends to continue to incorporate requirements of the code of federal regulations by reference, that the incorporations be very specific. Because the title of 10 CSR 10-6.200 is "Hospital and Medical Infectious Waste Incinerators" EPA recommends that the department consider incorporating by reference only the related requirements of 40 CFR 60, subpart Ce into the Missouri Air Conservation Commission rule.

RESPONSE: The department incorporated only the specific sections of 40 CFR 60, subpart Ce that were necessary for the rule. Those specific sections can be found in subsection (2)(A) and sections (3) and (4) of the rule. No change was made to the rule text as a result of this comment.

COMMENT #10: Since proposal of the rule amendment, department staff determined that the proposed amendment may be interpreted to suggest that a previously mandatory obligation had become discretionary. The proposed amendment would modify the language of that requirement from "shall" to "have to." Because those terms may have different legal effect, the change may be misinterpreted.

RESPONSE AND EXPLANATION OF CHANGE: The department is revising the language to retain the word "shall" in order to clarify the obligation for facilities.

10 CSR 10-6.200 Hospital, Medical, Infectious Waste Incinerators

(1) Applicability.

(I) Facilities subject to this rule shall operate pursuant to a permit issued under the permitting authorities operating permit program.

Title 10—DEPARTMENT OF NATURAL RESOURCES Division 10—Air Conservation Commission Chapter 6—Air Quality Standards, Definitions, Sampling and Reference Methods and Air Pollution Control Regulations for the Entire State of Missouri

ORDER OF RULEMAKING

By the authority vested in the Missouri Air Conservation Commission under section 643.050, RSMo 2016, the commission rescinds a rule as follows:

10 CSR 10-6.362 Clean Air Interstate Rule Annual NO_x Trading Program is rescinded.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on May 15, 2018 (43 MoReg 1046). No changes were made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Air Pollution Control Program received five (5) comments on this rulemaking from the U.S. Environmental Protection Agency (EPA).

Due to similar concerns expressed in the following five (5) comments, one (1) response that addresses these concerns is at the end of these five (5) comments.

COMMENT #1: The EPA provided a general comment for all the rules that the department has the responsibility to ensure that the State Implementation Plan (SIP) revision submitted to EPA meets the requirements of sections 110(1) and 193 of the Clean Air Act (CAA).

Section 110(1): Generally, Section 110(1) provides that EPA cannot approve a SIP revision if the revision interferes with any applicable requirement concerning attainment and reasonable further progress or any other requirement of the CAA. This section applies to any area and to any National Ambient Air Quality Standard (NAAQS) pollutant and/or precursor. Thus, any SIP rule is subject to this section.

Section 193: Section 193 prohibits modification of a SIP in effect before 1990 unless that modification would ensure equivalent or greater emissions reductions, i.e., "anti-backsliding." Section 193 applies only to nonattainment areas and is specific to the nonattainment pollutant. The applicability of section 193 is specific to nonattainment "criteria" pollutants. The ozone implementation rule (codified at 40 CFR 51.905(a)(4)), describes how section 193 applies to Kansas City - an attainment area for the eight (8)-hour standard and maintenance area for the one (1)-hour standard.

Each of the eleven (11) proposed rule rescissions are subject to section 110(1) requirements; six (6) of the proposed rule rescissions are subject to the section 193 requirements. One (1) of the seven (7) proposed rule revisions is subject to section 110(1) requirements, one (1) is a Title V Part 70 revision, one (1) is a 111(d) plan revision, and the remaining four (4) proposed rule revisions are administrative in nature only.

COMMENT #2: The EPA suggests a demonstration that quantifies any emissions increase or potential increase by rescinding the rule(s), and a discussion on the impact on air quality. This demonstration could be done by comparing the source inventory at the time the rule was promulgated to the source inventory now, and demonstrating the overall impact on emissions. In addition, the department could include a discussion of the monitored air quality when the rule was promulgated/incorporated into the SIP and monitored air quality trends that demonstrate an improvement in air quality and how the rescission of the rule might impact those trends.

COMMENT #3: The EPA suggests a discussion of the rule's purpose;

specifically, whether the rule was promulgated to meet nonattainment area requirements, and if so, which specific NAAQS. In addition, the department could describe how the rule no longer serves to meet that purpose or how the rule has been superseded by another permanent and enforceable mechanism.

COMMENT #4: The EPA suggests a discussion of whether the rule was used to support other actions and whether the removal of the rule would impact those obligations such as an attainment demonstration, a request for a determination to attainment, a redesignation request and maintenance plan, or other actions such as Regional Haze or Interstate Transport.

COMMENT #5: The EPA suggests that where the department may be anticipating other federal programs, such as Maximum Achievable Control Technology and National Emissions Standards for Hazardous Air Pollutants, as acting as a backstop to removal of its Reasonably Available Control Technology (RACT) rules, a comprehensive discussion of how those programs equal RACT. For example, there may be volatile organic compound (VOC) sources regulated by these programs that are well-controlled through add-on controls, or even through substitution of non-hazardous air pollutant material for VOC hazardous air pollutant materials, however, these programs only cover air toxics and not all VOC emissions that RACT would capture and control are air toxics.

RESPONSE: The rescission of this rule is consistent with Executive Order 17-03 requiring a review of every regulation to affirm that the regulation is essential to the health, safety, or welfare of Missouri residents. The review of this rule indicated that no sources are subject to the rule, that the rule does not reduce any air pollutant, and therefore is not essential. Previously subject sources either have gone out of business or the source is no longer subject to the rule. In some cases, the source has been out of business or not subject to the rule for years. To address EPA's concern about limiting VOC emissions from a new source, the department reiterates that RACT rules were intended to apply to existing major sources in nonattainment areas present at the time of the rule's promulgation. Any new source would not be subject to a RACT rule and instead would be subject to current applicable state or federal rules. Those state and federal rules would serve as the backstop limiting VOC emissions. These rules are not relied upon for any SIP purposes.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 6—Air Quality Standards, Definitions,
Sampling and Reference Methods and Air Pollution
Control Regulations for the Entire State of Missouri

ORDER OF RULEMAKING

By the authority vested in the Missouri Air Conservation Commission under section 643.050, RSMo 2016, the commission rescinds a rule as follows:

10 CSR 10-6.364 Clean Air Interstate Rule Seasonal NO_x Trading Program is rescinded.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on May 15, 2018 (43 MoReg 1047). No changes were made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Air Pollution Control Program received six (6) comment on this rulemaking from the U.S. Environmental Protection Agency (EPA).

Due to similar concerns expressed in the following five (5) com-

ments, one (1) response that addresses these concerns is at the end of these five (5) comments.

COMMENT #1: The EPA provided a general comment for all the rules that the department has the responsibility to ensure that the State Implementation Plan (SIP) revision submitted to EPA meets the requirements of sections 110(1) and 193 of the Clean Air Act (CAA).

Section 110(1): Generally, Section 110(1) provides that EPA cannot approve a SIP revision if the revision interferes with any applicable requirement concerning attainment and reasonable further progress or any other requirement of the CAA. This section applies to any area and to any National Ambient Air Quality Standard (NAAQS) pollutant and/or precursor. Thus, any SIP rule is subject to this section.

Section 193: Section 193 prohibits modification of a SIP in effect before 1990 unless that modification would ensure equivalent or greater emissions reductions, i.e., "anti-backsliding." Section 193 applies only to nonattainment areas and is specific to the nonattainment pollutant. The applicability of section 193 is specific to nonattainment "criteria" pollutants. The ozone implementation rule (codified at 40 CFR 51.905(a)(4)), describes how section 193 applies to Kansas City - an attainment area for the eight (8)-hour standard and maintenance area for the one (1)-hour standard.

Each of the eleven (11) proposed rule rescissions are subject to section 110(1) requirements; six (6) of the proposed rule rescissions are subject to the section 193 requirements. One (1) of the seven (7) proposed rule revisions is subject to section 110(1) requirements, one (1) is a Title V Part 70 revision, one (1) is a 111(d) plan revision, and the remaining four (4) proposed rule revisions are administrative in nature only.

COMMENT #2: The EPA suggests a demonstration that quantifies any emissions increase or potential increase by rescinding the rule(s), and a discussion on the impact on air quality. This demonstration could be done by comparing the source inventory at the time the rule was promulgated to the source inventory now, and demonstrating the overall impact on emissions. In addition, the department could include a discussion of the monitored air quality when the rule was promulgated/incorporated into the SIP and monitored air quality trends that demonstrate an improvement in air quality and how the rescission of the rule might impact those trends.

COMMENT #3: The EPA suggests a discussion of the rule's purpose; specifically, whether the rule was promulgated to meet nonattainment area requirements, and if so, which specific NAAQS. In addition, the department could describe how the rule no longer serves to meet that purpose or how the rule has been superseded by another permanent and enforceable mechanism.

COMMENT #4: The EPA suggests a discussion of whether the rule was used to support other actions and whether the removal of the rule would impact those obligations such as an attainment demonstration, a request for a determination to attainment, a redesignation request and maintenance plan, or other actions such as Regional Haze or Interstate Transport.

COMMENT #5: The EPA suggests that where the department may be anticipating other federal programs, such as Maximum Achievable Control Technology and National Emissions Standards for Hazardous Air Pollutants, as acting as a backstop to removal of its Reasonably Available Control Technology (RACT) rules, a comprehensive discussion of how those programs equal RACT. For example, there may be volatile organic compound (VOC) sources regulated by these programs that are well-controlled through add-on controls, or even through substitution of non-hazardous air pollutant material for VOC hazardous air pollutant materials, however, these programs only cover air toxics and not all VOC emissions that RACT would capture and control are air toxics.

RESPONSE: The rescission of this rule is consistent with Executive Order 17-03 requiring a review of every regulation to affirm that the regulation is essential to the health, safety, or welfare of Missouri residents. The review of this rule indicated that no sources are subject to the rule, that the rule does not reduce any air pollutant, and therefore

is not essential. Previously subject sources either have gone out of business or the source is no longer subject to the rule. In some cases, the source has been out of business or not subject to the rule for years. To address EPA's concern about limiting VOC emissions from a new source, the department reiterates that RACT rules were intended to apply to existing major sources in nonattainment areas present at the time of the rule's promulgation. Any new source would not be subject to a RACT rule and instead would be subject to current applicable state or federal rules. Those state and federal rules would serve as the backstop limiting VOC emissions. These rules are not relied upon for any SIP purposes.

COMMENT #6: The Rulemaking Report indicates that this rule is being proposed for rescission because it is no longer necessary and has been superseded by the Cross-State Air Pollution Rule (CSAPR) trading program. However, there are two (2) remaining issues to be addressed by the department even with the current federal implementation of the CSAPR: 1) the nitrogen oxide (NO_x) SIP Call mass emissions cap for existing and new units, and 2) the 40 CFR 75, subpart H monitoring requirements. NO_x SIP Call states, like Missouri, that brought large non-electric generating units (EGUs) into the Clean Air Interstate Rule (CAIR) NO_x ozone season trading program have not brought those units into the CSAPR NO_x ozone season trading program. Although the CSAPR essentially covers states' NO_x SIP Call obligations for large EGUs, by default the CSAPR does not cover large non-EGUs. As such, the department would need to submit a SIP revision to address the state's NO_x SIP Call requirements for the large non-EGU reductions in some other way. With respect to the NO_x SIP Call mass emissions cap requirements, it is important to note that, regardless if the state finalizes the rescission of 10 CSR 10-6.364, the issue will need resolution through a SIP revision. The EPA is willing to work with the department on developing a SIP revision using any option that the state may offer.

RESPONSE: Missouri initially had three (3) non-EGU boilers subject to both the NO_x SIP Call and the CAIR ozone season trading programs (10 CSR 10-6.360 and 10 CSR 10-6.364) and were allocated NO_x allowances for each program. The NO_x SIP Call has been superseded by CAIR, which has been replaced with CSAPR. The CSAPR ozone season trading program did not include non-EGUs, and new units cannot opt-in to this program. All three (3) of the non-EGU units in Missouri subject to the CAIR ozone season trading program (and formally subject to the NO_x SIP Call) have ceased operation. The department recognizes that EPA has concerns with two (2) remaining issues. As noted in EPA's comment, EPA believes a SIP revision will be needed regardless if the rule is rescinded and is willing to work with the department to address EPA concerns.

**Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
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Sampling and Reference Methods and Air Pollution
Control Regulations for the Entire State of Missouri**

ORDER OF RULEMAKING

By the authority vested in the Missouri Air Conservation Commission under section 643.050, RSMo 2016, the commission rescinds a rule as follows:

**10 CSR 10-6.366 Clean Air Interstate Rule SO₂ Trading Program
is rescinded.**

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on May 15, 2018 (43 MoReg 1047). No changes were made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Air Pollution Control Program received five (5) comments on this rulemaking from the U.S. Environmental Protection Agency (EPA).

Due to similar concerns expressed in the following five (5) comments, one (1) response that addresses these concerns is at the end of these five (5) comments.

COMMENT #1: The EPA provided a general comment for all the rules that the department has the responsibility to ensure that the State Implementation Plan (SIP) revision submitted to EPA meets the requirements of sections 110(1) and 193 of the Clean Air Act (CAA).

Section 110(1): Generally, Section 110(1) provides that EPA cannot approve a SIP revision if the revision interferes with any applicable requirement concerning attainment and reasonable further progress or any other requirement of the CAA. This section applies to any area and to any National Ambient Air Quality Standard (NAAQS) pollutant and/or precursor. Thus, any SIP rule is subject to this section.

Section 193: Section 193 prohibits modification of a SIP in effect before 1990 unless that modification would ensure equivalent or greater emissions reductions, i.e., "anti-backsliding." Section 193 applies only to nonattainment areas and is specific to the nonattainment pollutant. The applicability of section 193 is specific to nonattainment "criteria" pollutants. The ozone implementation rule (codified at 40 CFR 51.905(a)(4)), describes how section 193 applies to Kansas City - an attainment area for the eight (8)-hour standard and maintenance area for the one (1)-hour standard.

Each of the eleven (11) proposed rule rescissions are subject to section 110(1) requirements; six (6) of the proposed rule rescissions are subject to the section 193 requirements. One (1) of the seven (7) proposed rule revisions is subject to section 110(1) requirements, one (1) is a Title V Part 70 revision, one (1) is a 111(d) plan revision, and the remaining four (4) proposed rule revisions are administrative in nature only.

COMMENT #2: The EPA suggests a demonstration that quantifies any emissions increase or potential increase by rescinding the rule(s), and a discussion on the impact on air quality. This demonstration could be done by comparing the source inventory at the time the rule was promulgated to the source inventory now, and demonstrating the overall impact on emissions. In addition, the department could include a discussion of the monitored air quality when the rule was promulgated/incorporated into the SIP and monitored air quality trends that demonstrate an improvement in air quality and how the rescission of the rule might impact those trends.

COMMENT #3: The EPA suggests a discussion of the rule's purpose; specifically, whether the rule was promulgated to meet nonattainment area requirements, and if so, which specific NAAQS. In addition, the department could describe how the rule no longer serves to meet that purpose or how the rule has been superseded by another permanent and enforceable mechanism.

COMMENT #4: The EPA suggests a discussion of whether the rule was used to support other actions and whether the removal of the rule would impact those obligations such as an attainment demonstration, a request for a determination to attainment, a redesignation request and maintenance plan, or other actions such as Regional Haze or Interstate Transport.

COMMENT #5: EPA suggests that where the department may be anticipating other federal programs, such as Maximum Achievable Control Technology and National Emissions Standards for Hazardous Air Pollutants, as acting as a backstop to removal of its Reasonably Available Control Technology (RACT) rules, a comprehensive discussion of how those programs equal RACT. For example, there may be volatile organic compound (VOC) sources regulated by these programs that are well-controlled through add-on controls, or even through substitution of non-hazardous air pollutant material for VOC hazardous air pollutant materials, however, these programs only cover air toxics and not all VOC emissions that RACT would capture

and control are air toxics.

RESPONSE: The rescission of this rule is consistent with Executive Order 17-03 requiring a review of every regulation to affirm that the regulation is essential to the health, safety, or welfare of Missouri residents. The review of this rule indicated that no sources are subject to the rule, that the rule does not reduce any air pollutant, and therefore is not essential. Previously subject sources either have gone out of business or the source is no longer subject to the rule. In some cases, the source has been out of business or not subject to the rule for years. While a rule may have applied to a source to reduce or limit air pollutants in the past, the source is no longer producing the regulated emissions and the rule is no longer needed or relied upon for emission reductions going forward. To address EPA's concern about limiting VOC emissions from a new source, the department reiterates that RACT rules were intended to apply to existing major sources in nonattainment areas present at the time of the rule's promulgation. Any new source would not be subject to a RACT rule and instead would be subject to current applicable state or federal rules. Those state and federal rules would serve as the backstop limiting VOC emissions. These rules are not relied upon for any SIP purposes.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 20—Clean Water Commission
Chapter 2—Definitions

ORDER OF RULEMAKING

By the authority vested in the Clean Water Commission of the State of Missouri under sections 536.023(3) and 644.026, RSMo 2016, the commission amends a rule as follows:

10 CSR 20-2.010 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on June 1, 2018 (43 MoReg 1148-1153). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: A public hearing on this proposed amendment was held July 16, 2018, and the public comment period ended July 25, 2018. At the public hearing, department staff provided testimony on the proposed amendment. One (1) comment was received during the public hearing from Mr. Robert Brundage with Newman, Comley & Ruth, PC. The department received four (4) comment letters from three (3) individuals during the public comment period.

PUBLIC COMMENTS:

COMMENT #1: Mr. Robert Brundage with Newman, Comley & Ruth, PC and Mr. Stanley Thessen, MFA, both provided comments on returning the agrichemical definition to the rule. Mr. Thessen commented that other definitions in the rule utilized the term agrichemical.

RESPONSE AND EXPLANATION OF CHANGE: The definition for agrichemical was reinstated into the rule.

COMMENT #2: Mr. Paul Calamita with the Association of Clean Water Agencies, recommended adding "Blending is not a bypass" to the definition of bypass.

RESPONSE AND EXPLANATION OF CHANGE: A statement was added to the end of the bypass definition stating that blending is not a bypass.

COMMENT #3: Mr. Robert Brundage with Newman, Comley & Ruth, PC and Mr. Stanley Thessen, MFA, both recommended retain-

ing the definition of "Dedicated agrichemical container."

RESPONSE AND EXPLANATION OF CHANGE: The definition was modified to eliminate the prescriptive language and returned to the rule.

COMMENT #4: Mr. Robert Brundage with Newman, Comley & Ruth, PC and Mr. Stanley Thessen, MFA, both recommended removal of the definition for "Emergency and discharge response plan." Mr. Thessen also questioned how the definition relates to Missouri Clean Water Commission regulations and how the federal requirement was cited in the definition.

RESPONSE AND EXPLANATION OF CHANGE: The Emergency and discharge response plans are required under Emergency Planning and Community Right to Know Act previously referenced in 10 CSR 20-8.500(13). The 10 CSR 20-8.500(13) reference is being proposed for deletion. The definition for "Emergency and discharge response plan" is being removed from the definitions rule.

COMMENT #5: Mr. Robert Brundage with Newman, Comley & Ruth, PC provided written comment and verbal testimony at the July 16, 2018, hearing on the procedures being part of the definition of losing stream and the procedures are not currently in rule. Also he commented on the definition of the term, bedrock aquifer, in the existing definition.

RESPONSE AND EXPLANATION OF CHANGE: The losing stream definition is being modified to remove the determination procedures from the definition. This is a definitions rule and should not set how determinations are made. On the question of bedrock aquifer, this is being deleted in the modified definition; however the United State Geological Survey defines that as an aquifer composed of consolidated material such as limestone, dolomite, sandstone, siltstone, shale, or fractured crystalline rock (Atlas of Water Resources in the Black Hills Area, South Dakota, pg. 118, <https://pubs.usgs.gov/ha/ha747/pdf/definition.pdf>). Further discussion with stakeholders on the existing process for determining losing stream and if that process should be included in rule will be undertaken separate of this rulemaking.

COMMENT #6: Mr. Robert Brundage with Newman, Comley & Ruth, PC and Mr. Stanley Thessen, MFA, commented that the reference to Missouri Department of Transportation standards was incorrect in the definition of "Mobile Container."

RESPONSE AND EXPLANATION OF CHANGE: The definition has been updated to reference United States Department of Transportation standards.

COMMENT #7: Mr. Robert Brundage with Newman, Comley & Ruth, PC stated that a more precise citation should be used for "new source" and "pollutant."

RESPONSE: The citations in the rule follow the direction from the Secretary of State's Office for citing federal regulations. No changes were made to the definition.

COMMENT #8: Mr. Robert Brundage with Newman, Comley & Ruth, PC and Mr. Stanley Thessen, MFA, provided comments on the definition of no-discharge being self-contradictory with the inclusion of the term "treatment facility" and conflicts with statute.

RESPONSE AND EXPLANATION OF CHANGE: There are some circumstances where treatment does not occur and as such the term "treatment" is being deleted from the definition.

COMMENT #9: Mr. Robert Brundage with Newman, Comley & Ruth, PC provided comment on the definition of "operating location" and specifically the proposed deletion of the terminology "in common."

RESPONSE AND EXPLANATION OF CHANGE: The term "in common" is a legal term and will be retained.

COMMENT #10: Mr. Robert Brundage with Newman, Comley & Ruth, PC and Mr. Stanley Thessen, MFA, provided comments on the definition of rinsate, including the removal of the term agrichemical, that the rule should say contaminants not contaminants, and the broadening of the definition. Additionally, they raised concern that the proposed exemption in 10 CSR 20-6.010 would be expanded to other industries as an unintended consequence.

RESPONSE AND EXPLANATION OF CHANGE: The removal of the term agrichemical was a result of the stakeholder meetings as other industries use the term in response to their wastewater. The rule has been corrected to state contaminants. In the proposed 10 CSR 20-6.010, the term agrichemical will be added to limit the proposed exemption, as the exemption was developed for the agrichemical rinsates.

COMMENT #11: Mr. Robert Brundage with Newman, Comley & Ruth, PC and Mr. Stanley Thessen, MFA, commented on the definition of “secondary containment” and that it was being expanded to include additional facilities and may be creating additional cost to facilities with the proposed requirement to surround. Mr. Brundage recommended removing the word “surround” and deleting the words “solids, liquids and gaseous chemical.”

RESPONSE AND EXPLANATION OF CHANGE: Secondary containment requirements are present in other regulations than 10 CSR 20-8.500 and the existing definition was not comprehensive. As this is a definition rule, it is not intended to set requirements on facilities, but to provide a definition of terms used in the other chapters of 10 CSR 20 that have requirements associated. The definition has been changed to reflect the recommendations from Mr. Brundage.

COMMENT #12: Mr. Stanley Thessen, MFA, commented that the rulemaking was beyond the scope of the purpose statement in the amendment and asked for an explanation of how the definitions are being changed to meet current statutes, federal definitions or current terminology.

RESPONSE AND EXPLANATION OF CHANGE: The amendment now references twenty-eight (28) statute definitions and five (5) federal definitions. The other sections being amended were discussed with stakeholders and changed for additional clarity and industry standard terminology. Changes were made throughout the rule, such as the definition of mobile container, as a result of the previous comments.

COMMENT #13: Mr. Stanley Thessen, MFA, disagreed that the cost estimate was less than five hundred dollars (\$500) due to expanding the definition of secondary containment and should be considered with the context of other concurrent rulemaking revisions.

RESPONSE: 10 CSR 20-2.010 sets no environmental requirements and as such is an administrative rule. The cost should be considered with rules that have direct requirements on the facilities. The definition of secondary containment was incorrect previously and applicable to more facilities than just agrichemical facilities. No changes were made as a result of this comment.

COMMENT #14: Mr. Stanley Thessen, MFA, questioned the public hearing being before the end of the public comment period and how could the department hold a meeting before the public comment period was closed.

RESPONSE: Previously the department held stakeholder meetings to allow comments and discussion on the development of the rule. The public hearing is not where the department responds to comments. According to 644.036.2, RSMo, a public hearing is held a minimum of seven (7) days before the public comment period closes to allow the public to make verbal comments to be considered along with the written comments received. No changes were made as a result of this comment.

10 CSR 20-2.010 Definitions

(2) “Agrichemical,” any pesticide or fertilizer but does not include anhydrous ammonia fertilizer material.

(3) “Agrichemical facility,” any site, with the exception of chemical production facilities, where bulk pesticides or fertilizers, excluding anhydrous ammonia fertilizer, are stored in non-mobile containers or dedicated containers and are being mixed, applied, repackaged, or transferred between containers for more than thirty (30) consecutive days per year.

(4) “Application,” the application form supplied by the department, the filing fee, if applicable, and other supporting documents if requested.

(5) “Appurtenances,” valves, pumps, fittings, pipes, hoses, plumbing, or metering devices connected to sewers, basins, tanks, storage vessels, treatment units, and discharge or delivery structures, or used for transferring products or wastes.

(6) “Aquaculture facility,” as defined by section 644.016(1), RSMo.

(7) “Aquifer,” a subsurface water-bearing bed or stratum which stores or transmits water in recoverable quantities that is presently being utilized or could be utilized as a water source for private or public use. It does not include water in the vadose zone. For purpose of the effluent regulation, sandy or gravelly alluvial soils in or on the floodplains of intermittent streams are not an aquifer.

(8) “Blending,” the practice of diverting wet-weather flows around any treatment unit and recombining those flows within the treatment facility, while providing primary and secondary or biological treatment up to the available capacity, consistent with all applicable effluent limits and conditions. See bypass, section (11) of this rule.

(9) “Bulk fertilizer,” any liquid or dry fertilizer which is transported or stored in undivided quantities of greater than five hundred (500) gallons measure or five thousand (5,000) pounds net dry weight respectively.

(10) “Bulk pesticide,” any registered pesticide which is transported or stored in an individual container in undivided quantities greater than fifty-six (56) gallons liquid measure or one hundred (100) pounds dry weight respectively.

(11) “Bulk repackaging,” the transfer of a registered pesticide from one (1) container to another in an unaltered state in preparation for sale to or distribution for use by another person.

(12) “Bypass,” as defined by 40 CFR part 122 subpart C, October 22, 2015, as published by the EPA Docket Center, EPA West 1301 Constitution Avenue NW., Washington, DC 20004, is incorporated by reference. This rule does not incorporate any subsequent amendments or additions. Blending is not a bypass.

(13) “Clean Water Act,” the Clean Water Act (formerly referred to as the Federal Water Pollution Control Act or Federal Water Pollution Control Act Amendments of 1972) (P.L. 92- 500) as amended in 1977, (P.L. 95-217), 1978 (P.L. 95-576), 1980 (P.L. 96-483), and in 1981 (P.L. 97-117), 33 U.S.C. 1251 et seq, as published by the Office of the Law Revision Counsel, U.S. House of Representatives, H2-308 Ford House Office Building, Washington, DC 20515, are incorporated by reference. This rule does not incorporate any subsequent amendments or additions.

(14) “Commission,” as defined by section 644.016(2), RSMo.

(15) “Common promotional plan,” a plan, undertaken by one (1) or more persons, to offer individual lots or residential housing units within a residential housing development for sale or lease; where land or residential housing units are offered for sale or lease by a person or group of persons acting in concert, and the land is contiguous or is known, designated, or advertised as a common unit or by a common name or similar names, the land is presumed, without regard to the number of lots or residential housing units covered by each individual offering, as being offered for sale or lease as part of a common promotional plan. State and county roads are not considered property boundaries.

(16) “Composite sample,” a combination of individual samples collected over a designated period of time.

(17) “Conference, conciliation, and persuasion,” as defined by section 644.016(3), RSMo.

(18) “Construction,” any activities including, but not limited to, the erection, installation, or significant modification of any dwelling, structure, building, sewer system, water contaminant source, or point source. Construction commences with any preparatory activity including, but not limited to, trenching, excavation for any building in a subdivision, or for a wastewater treatment facility, demolition of existing wastewater treatment facility structures or change in the wastewater treatment facility operation necessary to allow modification, but not to include interior remodeling of single-family residences or commercial buildings which will not result in a substantial change in wastewater volume, nature, or strength of the discharge therefrom.

(19) “Continuing authority,” is a person, as defined in 644.016(15), RSMo, that is either an area wide management authority or owns and/or operates a point source, treatment facility, or a sewer collection system.

(20) “Daily maximum,” an effluent limitation that specifies the total mass or average concentration of pollutants that may be discharged in a calendar day.

(21) “Dedicated agrichemical container,” a container effectively designed and constructed to hold a specific agrichemical and to be reused, repackaged, or refilled.

(22) “Department,” as defined by section 644.016(4), RSMo.

(23) “Developer,” any person or group of persons who directly or indirectly, sells or leases or offers to sell or lease, any lots, residential housing units, or recreational camping sites, but not to include any licensed broker or licensed salesman who is not a shareholder, director, officer, or employee of a developer and who has no legal or equitable interest in the land.

(24) “Director,” as defined by section 644.016(5), RSMo.

(25) “Discharge,” as defined by section 644.016(6), RSMo.

(26) “Domestic wastewater,” wastewater (i.e., human sewage) originating primarily from the sanitary conveniences of residences, commercial buildings, factories, and institutions, including any water which may have infiltrated the sewers. Domestic wastewater excludes stormwater, animal waste, process waste, and other similar waste.

(27) “Effluent,” any wastewater or other substance flowing out of or released from a point source, water contaminant source, or wastewater treatment facility.

(28) “Effluent Control Regulations,” as defined by section

644.016(7), RSMo.

(29) “Effluent limitation segment,” any segment of water where the water quality meets and will continue to meet water quality standards or where the water quality will meet water quality standards after the application of effluent limitation guidelines.

(30) “Engineer,” as defined by section 327.011(13), RSMo.

(31) “Environmental Protection Agency (EPA),” the United States Environmental Protection Agency.

(32) “Fertilizer,” as defined by section 266.291, RSMo.

(33) “Filing fee,” a credit card, check, money order, or bank draft payable to the state of Missouri as filing fee for a construction permit, an operating permit, or a variance.

(34) “General permit,” as defined by section 644.016(8), RSMo.

(35) “General permit template,” as defined by section 644.016(9), RSMo.

(36) “Grab sample,” any individual sample collected without compositing or adding other samples.

(37) “Human sewage,” as defined in section 644.016(10), RSMo.

(38) “Innovative technology,” new and generally unproven technology in the type or method of its application that bench testing or theory suggests has environmental, efficiency, and cost benefits beyond standard technologies.

(39) “Lagoon,” an earthen basin or lined basin used for biological treatment of wastewater, usually designed for biochemical oxygen demand (BOD) removal and settling of solids. Lagoons can be designed as flow-through, controlled discharge, no-discharge systems, or for storage.

(40) “Losing streams,” a stream which distributes thirty percent (30%) or more of its flow during low flow conditions through natural processes. Losing streams are identified in the digital geospatial dataset ‘LOSING_STREAM’ developed by the Missouri Department of Natural Resources, Missouri Geological Survey; additional streams may be determined to be losing by the department.

(41) “Lot,” any portion, piece, division, unit, or undivided interest in real estate, if the interest includes the right to the exclusive use of a specific portion of real estate, whether for a specific term or in perpetuity.

(42) “Minor Violation,” as defined by section 644.016(12), RSMo.

(43) “Missouri Clean Water Law,” as defined by sections 644.006 through 644.141, RSMo.

(44) “Mobile container,” a container designed and used for transporting agrichemicals that meet the United States Department of Transportation standards for the product being transported.

(45) “Monthly average,” the total mass or concentration of all daily discharges sampled during a calendar month divided by the number of daily discharges sampled or measured during that month.

(46) “Municipality,” an incorporated city, town, or village (including an intermunicipal agency of two (2) or more of the foregoing entities).

(47) "National Pollutant Discharge Elimination System (NPDES)," as defined in the Clean Water Act. See Clean Water Act, section (12) of this rule.

(A) NPDES permit. Any permit issued by either the EPA or the state of Missouri under authorization by EPA which fulfills the NPDES requirements as set forth in the Clean Water Act.

(B) NPDES application. Any application on a form supplied by the department, submitted for an NPDES permit.

(48) "New discharger," any building, structure, facility or installation—

(A) Which on October 18, 1972, has never discharged pollutants;

(B) Which has never received a finally effective NPDES permit;

(C) From which there is or may be a new or additional discharge of pollutants; and

(D) Which does not fall within the definition of new source.

(49) "New source," as defined by 40 CFR part 122 subpart A, June 29, 2015, as published by the EPA Docket Center, EPA West 1301 Constitution Avenue NW., Washington, DC 20004, are incorporated by reference. This rule does not incorporate any subsequent amendments or additions.

(50) "No-discharge," a facility designed, constructed, and operated to hold or irrigate, or otherwise dispose without discharge to surface or subsurface waters of the state, all process wastes and associated stormwater flows except for discharges that are caused by catastrophic and chronic storm events; any basin is sealed in accordance with 10 CSR 20-8, Minimum Design Standards; and no subsurface releases exist in violation of 10 CSR 20-7.015, Effluent Regulations, or section 577.155, RSMo.

(51) "Non-mobile container," a stationary container designed to be incapable of movement once installed; not defined as mobile.

(52) "Operating location," all contiguous lands owned, operated, or controlled by one (1) or more persons jointly or as tenants in common.

(53) "Operation and maintenance," activities to assure the dependable and economical function of wastewater and stormwater systems.

(A) Maintenance. Preservation of functional integrity and efficiency of equipment and structures. The proper keeping of all aspects of a collection system and wastewater treatment facility and appurtenances thereto, that pertain to safety, in a state of repair and working order as necessary to comply with the Missouri Clean Water Law and any permit issued thereunder and to protect public health and safety. This includes preventive maintenance, corrective maintenance, and replacement of equipment as needed.

(B) Operation. Control of the unit processes and equipment which make up the wastewater treatment facility. This includes financial and personnel management, records, laboratory control, process control, safety, and emergency operation planning.

(54) "Operational area," an area(s) at an agrichemical facility where agrichemicals are transferred, loaded, unloaded, mixed, repackaged, refilled, or where agrichemicals are cleaned, washed, or rinsed from containers or equipment that is used in application, handling, storage, or transportation.

(55) "Operational containment area," any structure or system effectively designed and constructed to intercept and contain discharges, including container or equipment wash water, rinsates and precipitation, and to prevent escape, runoff, or leaking from the operational area.

(56) "Permit by rule," as defined by section 644.016(13), RSMo.

(57) "Permit holders or applicants for a permit," as defined by section 644.016(14), RSMo.

(58) "Person," as defined by section 644.016(15), RSMo.

(59) "Pesticide," as defined by section 281.020(18), RSMo.

(60) "Point source," as defined by section 644.016(16), RSMo.

(61) "Pollutant," as defined by 40 CFR part 122 subpart A, June 29, 2015, as published by the EPA Docket Center, EPA West 1301 Constitution Avenue NW., Washington, DC 20004, is incorporated by reference. This rule does not incorporate any subsequent amendments or additions.

(62) "Pollution," as defined by section 644.016(17), RSMo.

(63) "Pretreatment regulations," as defined by section 644.016(18), RSMo.

(64) "Primary containment," the storage of an agrichemical in either its original container or other suitable container, including dedicated containers, effectively designed and constructed to contain the product that may be stored there.

(65) "Publicly owned treatment works (POTW)," wastewater treatment facility and collection system which conveys wastewater to the POTW owned by the state, a municipality, a political subdivision or a sewer district defined by Chapters 644, 249, and 250, RSMo, 2016.

(66) "Regional administrator," regional administrator of the Environmental Protection Agency's regional office for the region in which the state of Missouri is located.

(67) "Release," to discharge directly or indirectly to waters of the state, or to place, cause, or permit to be placed, any water contaminant in any location where it is reasonably certain to enter waters of the state. For agrichemical facilities, this includes any spill, leak, deposit, dumping, or emptying of an agrichemical, process wastewater, or collected precipitation from a secondary containment area or operational containment area. Release does not include the lawful transfer, loading, unloading, repackaging, refilling, distribution, use, or application of an agrichemical, agrichemical process wastewater, or related collected precipitation.

(68) "Residence," any structure, dwelling, unit, or shelter which is intended or used for human habitation as a permanent, vacation, or recreational home or building. They may be detached or part of one (1) or more attached units.

(A) "Multiple-family," residential housing units that share the same structure, dwelling, unit, shelter, or common wall with or without a common social area that includes the right to the exclusive use of a specific portion of real estate, whether for a specific term or in perpetuity; they may include, but are not limited to, duplexes, condominiums, townhouses, apartments, hotels, motels, hospitals, dormitories, boarding schools, group homes, barracks, etc.

(B) "Single-family," an individual structure, dwelling, unit, or shelter constructed for the purpose of human habitation, with one (1) or more rooms occupied or intended for occupancy by one (1) family for cooking, sanitary, and sleeping purposes that includes the right to the exclusive use of a specific portion of real estate, whether for a specific term or in perpetuity; they do not include multiple-family residences.

(69) "Residential housing development," as defined by section 644.016(19), RSMo.

(70) “Rinsate,” any water containing contaminant that have been washed off or rinsed from containers, application equipment, handling or storage areas, or transportation equipment, including but not limited to: industrial chemicals, agrichemicals, or concrete.

(71) “Secondary containment,” any structure effectively designed and constructed to contain one (1) or more primary storage containers to collect any leaks or spills in the event of loss of integrity or primary container failure.

(72) “Separate storm sewer,” conveyance or systems of conveyances primarily used for conducting and conveying storm water runoff and located in an urbanized area or designated by the department as a separate storm sewer due to its size, its location, the quantity and nature of pollutants reaching the waters of the state, and other relevant factors.

(73) “Service area population,” the population to be served by a wastewater treatment facility.

(74) “Service connection,” the connection point of the service line and the sanitary sewer system which is operated and maintained by one (1) of the continuing authorities listed in 10 CSR 20-6.010(3)(B).

(75) “Seven- (7-) day Q10 stream flow,” the lowest average flow that occurs for seven (7) consecutive days that has a probable recurrence interval of once every ten (10) years.

(76) “Sewer extension,” sewer systems which are added to existing sewers and wastewater treatment facilities.

(77) “Sewer system,” as defined by section 644.016(20), RSMo.

(78) “Single family residence wastewater treatment facility,” any method or system for the treatment of domestic wastewater from a single-family residence.

(79) “Site-specific permit,” as defined by section 644.016(22), RSMo.

(80) “Small rural community,” a community of less than ten thousand (10,000) population and not located in whole or in part, in an area of St. Louis County or City encircled by Interstate Route 270, or in an area of Jackson, Clay, or Platte Counties encircled by State Route 150 and 291 and Interstate Routes 29 and 635.

(81) “Soil Scientist,” as defined by section 701.040.1.(2)(e), RSMo.

(82) “Stream,” a defined watercourse which carries water either continuously or intermittently and which is not entirely confined or located completely upon land owned, leased, or otherwise controlled by one (1) person.

(83) “Test hole,” a hole which has been drilled, bored, augered, or otherwise excavated in the exploration for mineral commodities or for obtaining geologic data. Test holes that penetrate only the residuum or unconsolidated materials and which do not enter a geologic unit, are deemed to be an aquifer, exempt from this definition.

(84) “Treatment facilities,” as defined by section 644.016(23), RSMo.

(85) “User charge,” a charge levied on users of a wastewater treatment facility for the user’s share of the costs of operation, maintenance, and replacement of the collection system and wastewater treatment facility.

(86) “Waste load allocation,” the amount of pollutants each discharger is allowed by the department to release into a given stream after the department has determined the total amount of pollutants that may be discharged into that stream without endangering its water quality.

(87) “Wastewater,” water or other liquids which carry or contain pollutants or water contaminants from any source.

(88) “Water contaminant,” as defined by section 644.016(24), RSMo.

(89) “Water contaminant source,” as defined by section 644.016(25), RSMo.

(90) “Waters of the state,” as defined by section 644.016(27), RSMo.

(91) “Water quality limited segment,” a segment where water quality does not meet and/or is not expected to meet applicable water quality standards even after the application of effluent limitations.

(92) “Weekly average,” the total mass or concentration of all daily discharges sampled during any calendar week divided by the number of daily discharges sampled or measured during that week.

Title 10—DEPARTMENT OF NATURAL RESOURCES

Division 70—Soil and Water Districts Commission

Chapter 2—Referendums

ORDER OF RULEMAKING

By the authority vested in the Soil and Water Districts Commission under section 278.080, RSMo 2016, the commission amends a rule as follows:

10 CSR 70-2.010 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 2, 2018 (43 MoReg 1437–1438). The public comment period extended from July 2, 2018 to August 1, 2018. Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources’ Soil and Water Conservation Program received ten (10) general comments for all five (5) chapters related to the Soil and Water Districts Commission’s rules from Mr. Ryan Britt, with the Missouri Association of Soil and Water Conservation Districts (MASWCD).

Due to similarity in nature of the comments, the comments are grouped together and one (1) response is provided.

COMMENT: The MASWCD made the following general comments regarding all proposed amendments to the Soil and Water Districts Commission rules in Chapter 2, 3, 4, 5, and 6: correct grammar and make sentences read better; make sentences gender neutral; make sentences more concise by adding or removing words; apply sentence structure and terms consistently in a rule or chapter; replace the term “installation” with “implementation” and the term “constructed” with “implemented”; replace the term “cost-sharing” with “cost-share”; replace the term “subdistrict” with “watershed district”; update and better describe program procedures; list general documents and non-formal names in lower case; and amend the definition of “State cost-share funds” to include “cost-share and incentive funds.”

RESPONSE AND EXPLANATION OF CHANGE: The department amended sections (1), (2), (3), (4), and (6) to address the general comments.

10 CSR 70-2.010 Conduct of Referendums

- (1) The process for the local committee and election judges is—
- (A) Publish successive notices of the referendum in one (1) or more newspapers in the county where the referendum is being held during each of the two (2) weeks immediately preceding the referendum;
 - (B) Open polls promptly at the time advertised;
 - (C) Furnish official ballots to each polling place; and
 - (D) Close the polls promptly at the closing hour designated but allow those who have entered the polling place before this time to complete their ballots.
- (2) If any elected judge is not present at the polls on the date and time of the referendum, the judges present may select any citizen in the district to serve as a judge and provide the necessary instructions.
- (3) Only one (1) vote is allowed per farm by the owner or the owner's legal representative. A tract of land must be operated as an independent farm enterprise to entitle its land representative to a single vote. Two (2) or more tracts of land that are operated by one (1) management entity as an independent farm enterprise will be entitled to one (1) vote.
- (4) Each landowner may personally cast one (1) vote per owned and independently operated farm. If the landowner is unable to personally vote, the landowner may give power of attorney to a taxpayer residing within the county to represent the landowner in the referendum.
- (6) Referendum and election tally sheets and all supplies should be returned to the clerk of the county court within twenty-four (24) hours after polls are closed, where they shall be safely preserved for twelve (12) months. If arrangements cannot be made with the county clerk, these materials shall be sent to the Soil and Water Districts Commission, PO Box 176, Jefferson City, MO 65102. The chair of the local committee and the clerk of the county court shall certify the total referendum vote by area and polling place and report the results to the chair of the Soil and Water Districts Commission.

Title 10—DEPARTMENT OF NATURAL RESOURCES Division 70—Soil and Water Districts Commission Chapter 2—Referendums

ORDER OF RULEMAKING

By the authority vested in the Soil and Water Districts Commission under section 278.080, RSMo 2016, the commission amends a rule as follows:

10 CSR 70-2.020 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 2, 2018 (43 MoReg 1438-1439). The public comment period extended from July 2, 2018 to August 1, 2018. Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Soil and Water Conservation Program received ten (10) general comments for all five (5) chapters related to the Soil and Water Districts Commission's rules from Mr. Ryan Britt, with

the Missouri Association of Soil and Water Conservation Districts (MASWCD).

Due to similar concerns expressed in the following three (3) comments, one (1) response that addresses these concerns is at the end of these (3) comments.

COMMENT: The MASWCD made the following general comments regarding all proposed amendments to the Soil and Water Districts Commission rules in Chapter 2, 3, 4, 5, and 6: correct grammar and make sentences read better; make sentences gender neutral; make sentences more concise by adding or removing words; apply sentence structure and terms consistently in a rule or chapter; replace the term "installation" with "implementation" and the term "constructed" with "implemented"; replace the term "cost-sharing" with "cost-share"; replace the term "subdistrict with "watershed district"; update and better describe program procedures; list general documents and non-formal names in lower case; and amend the definition of "State cost-share funds" to include "cost-share and incentive funds."

RESPONSE AND EXPLANATION OF CHANGE: The department amended section (1), section (2), subsection (3)(C), subsection (4)(A), and section (5) to address the general comments.

10 CSR 70-2.020 Conduct of Supervisor Elections

- (1) The Soil and Water Conservation District (SWCD) Board is responsible for conducting the election of supervisors in accordance with procedures established by the commission. Elections may be conducted electronically or with paper ballots.
- (2) The SWCD shall be partitioned by the commission into four (4) areas for the purpose of identifying candidates for the SWCD board.
- (3) To qualify for office, a candidate shall—
- (C) Reside in or own a farm lying in the same area where there is an expiring term; and
- (4) Eligibility for Voting.
- (A) Voting in SWCD supervisor elections is limited to one (1) vote per independent farm enterprise by a landowner or the landowner's legal representative. A legal representative must have a power of attorney that specifically authorizes voting in SWCD supervisor elections.
- (5) The election shall be certified by a majority of the board responsible for conducting the election. The SWCD Board of Supervisors shall complete and sign two (2) copies of the report and certification of supervisor election form. One (1) copy shall be mailed to the Soil and Water Conservation Program and one (1) copy shall be kept permanently in the SWCD files along with the tally sheet signed by the judges. After the election, the newly composed board shall select new officers and submit a list of the new officers to the Soil and Water Conservation Program.

Title 10—DEPARTMENT OF NATURAL RESOURCES Division 70—Soil and Water Districts Commission Chapter 3—Formation of Subdistrict

ORDER OF RULEMAKING

By the authority vested in the Soil and Water Districts Commission under section 278.080, RSMo 2016, the commission amends a rule as follows:

10 CSR 70-3.010 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 2, 2018 (43 MoReg 1439-1441). The public comment period extended from July 2, 2018 to August 1, 2018. Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Soil and Water Conservation Program received ten (10) general comments for all five (5) chapters related to the Soil and Water Districts Commission's rules from Mr. Ryan Britt, with the Missouri Association of Soil and Water Conservation Districts (MASWCD).

Due to similarity in nature of the comments, the comments are grouped together.

COMMENT #1: The MASWCD made the following general comments regarding all proposed amendments to the Soil and Water Districts Commission rules in Chapter 2, 3, 4, 5, and 6: correct grammar and make sentences read better; make sentences gender neutral; make sentences more concise by adding or removing words; apply sentence structure and terms consistently in a rule or chapter; replace the term "installation" with "implementation" and the term "constructed" with "implemented"; replace the term "cost-sharing" with "cost-share"; update and better describe program procedures; list general documents and non-formal names in lower case; and amend the definition of "State cost-share funds" to include "cost-share and incentive funds."

RESPONSE AND EXPLANATION OF CHANGE: The department amended the purpose section, section (2), section (5), section (6), section (9), section (11), and renumbered sections to address the general comments.

COMMENT #2: The MASWCD commented to replace the term "subdistrict" with "watershed district."

RESPONSE: Section 278.160, RSMo, that authorizes the creation of a subdistrict uses the term subdistrict not watershed district. In order to maintain consistency with the statute, the department did not change the term subdistrict in this chapter.

COMMENT #3: Following the public comment period, staff noticed that additional clarification was needed in describing the certification form in section (9).

RESPONSE AND EXPLANATION OF CHANGE: The department agrees and additional information was provided to better describe the certification form.

10 CSR 70-3.010 Formation of Soil and Water Conservation Subdistricts

PURPOSE: *This rule sets forth the basic procedures for the organization of a subdistrict within a soil and water conservation district.*

(1) Petition forms may be secured from the local soil and water conservation district board of supervisors or from the state commission office in Jefferson City, Missouri.

(2) The soil and water conservation district board should require certification by an elected county official that the signatures on the petition are those of landowners within the proposed subdistrict.

(3) The supervisors may divide a subdistrict into five (5) areas to nominate trustees.

(4) Landowners present at the hearing will nominate at least two (2) landowners from each of the five (5) designated areas, whose names will be placed on the ballot for election to serve as trustees of the

subdistrict.

(5) Landowners present at the hearing will select the polling places and judges for the referendum.

(6) Any landowner may be represented by a notarized proxy not more than one (1) year old.

(7) The voting will be on the question of establishing the proposed area as a subdistrict.

(8) Notice of the referendum shall be made in the same manner as the notice of the hearing and a copy of the notice shall be filed with the Soil and Water Districts Commission in Jefferson City.

(9) The district board shall certify the formation of the subdistrict in the official minutes of a district board meeting and record authentic copies of the certification form provided by the Soil and Water Districts Commission by filing it with the recorder of deeds of each county in which any portion of the subdistrict lies. The certification form shall also be filed with the Soil and Water Districts Commission in Jefferson City.

(10) Five (5) landowners representing the five (5) designated areas within the proposed subdistrict shall be elected to serve as trustees of the subdistrict. Elections shall not fall upon the date of any regular political election held in the county and a simple majority vote is needed to elect a trustee.

(11) The board of supervisors of a subdistrict shall submit to the Soil and Water Districts Commission copies of any rules, forms, or other documents used in pursuance of board duties and other information concerning board activities as the commission may require.

(12) If the boundary of a subdistrict intersects a property, no less than a legally described one-quarter of a quarter section of land (40 acres) shall be considered for tax assessment purposes.

Title 10—DEPARTMENT OF NATURAL RESOURCES Division 70—Soil and Water Districts Commission Chapter 4—Definitions

ORDER OF RULEMAKING

By the authority vested in the commission under section 278.080, RSMo 2016, the commission amends a rule as follows:

10 CSR 70-4.010 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 2, 2018 (43 MoReg 1441). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Soil and Water Conservation Program received seventeen (17) comments related to the Soil and Water Districts Commission's rules from Mr. Ryan Britt, with the Missouri Association of Soil and Water Conservation Districts (MASWCD).

Due to the similar nature of ten (10) comments, they are grouped and addressed together.

COMMENT #1: The MASWCD made the following general comments regarding all proposed amendments to the Soil and Water Districts Commission rules in Chapter 2, 3, 4, 5, and 6: correct

grammar and make sentences read better; make sentences gender neutral; make sentences more concise by adding or removing words; apply sentence structure and terms consistently in a rule or chapter; replace the term “installation” with “implementation” and the term “constructed” with “implemented”; replace the term “cost-sharing” with “cost-share”; replace the term “subdistrict with “watershed district”; update and better describe program procedures; list general documents and non-formal names in lower case; and amend the definition of “State cost-share funds” to include “cost-share and incentive funds.”

RESPONSE AND EXPLANATION OF CHANGE: The department amended subsections (1)(J), (1)(L), (1)(N), and (1)(O) and deleted subsection (1)(P) which defines “Tolerable soil loss limits” as this term is no longer listed elsewhere in the rules.

COMMENT #2: The MASWCD made the following comment: list definitions in 10 CSR 70-4.010 in alphabetical order.

RESPONSE AND EXPLANATION OF CHANGE: The department agrees and updated the rule accordingly.

COMMENT #3: The MASWCD made the following specific comment: include the term “cooperative working agreement” with “memorandum of understanding” in 10 CSR 70-4.010.

RESPONSE AND EXPLANATION OF CHANGE: The department agrees and updated the rule with this language.

COMMENT #4: The MASWCD made the following comment: include a definition of “Technician” in 10 CSR 70-4.010.

RESPONSE AND EXPLANATION OF CHANGE: The department agrees and updated the rule with this language.

COMMENT #5: The MASWCD made the following comment: amend the definition of “Farm” in 10 CSR 70-4.010.

RESPONSE AND EXPLANATION OF CHANGE: The department agrees and updated the definition of “Farm.”

COMMENT #6: The MASWCD made the following comment: amend the definition of “Landowner” in 10 CSR 70-4.010 to describe when the term “operator” can be used interchangeably with landowner.

RESPONSE: This language was in the proposed language during the public notice period. No additional change was made.

COMMENT #7: The MASWCD made the following comment: amend the definition of “State Soil and Water Districts Commission” in 10 CSR 70-4.010 to include other names it is listed by in the rules.

RESPONSE AND EXPLANATION OF CHANGE: The department agrees and updated the rule with this language.

COMMENT #8: The MASWCD made the following comment: amend the definition of “Board” in 10 CSR 70-4.010 to include the other names it is listed by in the rules.

RESPONSE: This language was in the proposed language during the public notice period. No additional change was made.

10 CSR 70-4.010 Definitions

(1) Definitions.

(A) Act means the Missouri Soil and Water Conservation Districts Law;

(B) Commission or Soil and Water Districts Commission or State Soil and Water Districts Commission means the agency created by section 278.080, RSMo for the administration of the soil and water conservation districts provided for by the Act;

(C) Conservation plan means the properly recorded decisions of the cooperating landowner on how the landowner plans, within practical limits, to use land in an operating unit within its capabilities and to treat it according to its needs for maintenance or improvement of

the soil, water, and other related resources;

(D) Cost-Share Program means the Missouri State Soil and Water Conservation Cost-Share Program created by the Missouri State Soil and Water Conservation Districts Act, Chapter 278, RSMo;

(E) District means a soil and water conservation district as defined in section 278.070(4), RSMo;

(F) District board or board or board of supervisors means the local governing body of a soil and water conservation district elected or appointed in accordance with the provisions of the Act;

(G) Eligible practice means a soil and water conservation practice designated as eligible for state cost-share funds by the commission in accordance with 10 CSR 70-5.020(1);

(H) Farm means land which has been assigned a United States Department of Agriculture Farm Service Agency (FSA) farm number or assessed as agricultural land by the county assessor where agriculture activities are normally performed and from which one thousand dollars (\$1000) or more of agriculture products are normally sold in a year;

(I) Land representative means the owner or representative authorized by power of attorney of any farm lying within an area proposed to be established, and subsequently established, as a soil and water conservation district under Chapter 278, RSMo. Each farm is entitled to representation by a land representative; provided, however, that the land representative is a taxpayer of the county within which the soil and water district is located;

(J) Landowner means any person, firm, or corporation holding title to any lands lying within a district organized or to be organized under the provisions of Chapter 278, RSMo. Any landowner may be represented by notarized power of attorney not more than one (1) year old. The term operator may be used interchangeably with landowner only for Chapter 5. The operator is the principal person who runs a farm by conducting or supervising the work, making day-to-day management decisions, and incurring expenses for applying or implementing conservation practices. The operator may be a landowner, tenant, lessee, or sublessee;

(K) NRCS means the United States Department of Agriculture Natural Resources Conservation Service;

(L) Participating district means a soil and water conservation district which is a party to a memorandum of understanding or a cooperative working agreement as determined by the commission, which is entered into in accordance with 10 CSR 70-5.010(1);

(M) Practice means any individual structure, conservation measure, or operation which constitutes a viable method of erosion abatement, sediment control, or protection of water quality;

(N) State cost-share funds means funds available through the Missouri State Soil and Water Conservation Cost-Share Program; and

(O) Technician means a person recognized by the commission as demonstrating acceptable technical knowledge and skills to evaluate and verify whether conservation practices meet required standards and specifications.

Title 10—DEPARTMENT OF NATURAL RESOURCES Division 70—Soil and Water Districts Commission Chapter 5—State Funded Cost-Share Program

ORDER OF RULEMAKING

By the authority vested in the Soil and Water Districts Commission under section 278.080, RSMo 2016, the commission amends a rule as follows:

10 CSR 70-5.010 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 2, 2018 (43 MoReg 1441-1442). The public comment period extended from

July 2, 2018 to August 1, 2018. Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Soil and Water Conservation Program received eleven (11) comments related to this rule from Mr. Ryan Britt, with the Missouri Association of Soil and Water Conservation Districts (MASWCD).

Due to the similar nature of ten (10) comments, they are grouped and addressed together.

COMMENT #1: The MASWCD made the following general comments regarding all proposed amendments to the Soil and Water Districts Commission rules in Chapter 2, 3, 4, 5, and 6: correct grammar and make sentences read better; make sentences gender neutral; make sentences more concise by adding or removing words; apply sentence structure and terms consistently in a rule or chapter; replace the term "installation" with "implementation" and the term "constructed" with "implemented"; replace the term "cost-sharing" with "cost-share"; replace the term "subdistrict with "watershed district"; update and better describe program procedures; list general documents and non-formal names in lower case; and amend the definition of "State cost-share funds" to include "cost-share and incentive funds."

RESPONSE AND EXPLANATION OF CHANGE: The department amended section (1) and subsection (2)(A) to address these comments.

COMMENT #2: The MASWCD, made the following comment: include the term "cooperative working agreement" with "memorandum of understanding" in 10 CSR 70-5.010.

RESPONSE AND EXPLANATION OF CHANGE: The department amended sections (1) and (3) to address these comments.

10 CSR 70-5.010 Allocation of Funds

(1) General Availability of Funds. State cost-share funds are available only to landowners located in soil and water conservation districts which have agreed to locally administer the program and have executed a memorandum of understanding or a cooperative working agreement with the commission setting forth the terms of assistance. To be eligible, a landowner must have a conservation plan approved by the district. Acceptable formats for preparing conservation plans are determined by the commission.

(2) Annual Allocation of Funds. All funds allocated to the cost-share program for any fiscal year shall be apportioned by the commission to the participating districts by considering the character of the districts' soil and water conservation needs according to criteria developed by the commission.

(A) Special Allocations. The commission may withhold funds from the general allocation for the purpose of providing cost-share for special projects which the commission considers necessary and of high priority for the saving of soil and water on Missouri's agricultural land.

(3) Termination of the Memorandum of Understanding or Cooperative Working Agreement. In the event that the memorandum of understanding or cooperative working agreement is terminated by any district or by the commission, the commission may withdraw funds assigned to that district.

Title 10—DEPARTMENT OF NATURAL RESOURCES Division 70—Soil and Water Districts Commission Chapter 5—State Funded Cost-Share Program

ORDER OF RULEMAKING

By the authority vested in the Soil and Water Districts Commission under section 278.080, RSMo 2016, the commission amends a rule as follows:

10 CSR 70-5.020 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 2, 2018 (43 MoReg 1442-1444). The public comment period extended from July 2, 2018 to August 1, 2018. Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Soil and Water Conservation Program received ten (10) comments related to this rule from Mr. Ryan Britt, with the Missouri Association of Soil and Water Conservation Districts (MASWCD).

Due to the similar nature of ten (10) comments, they are grouped and addressed together.

COMMENT #1: The MASWCD made the following general comments regarding all proposed amendments to the Soil and Water Districts Commission rules in Chapter 2, 3, 4, 5, and 6: correct grammar and make sentences read better; make sentences gender neutral; make sentences more concise by adding or removing words; apply sentence structure and terms consistently in a rule or chapter; replace the term "installation" with "implementation" and the term "constructed" with "implemented"; replace the term "cost-sharing" with "cost-share"; replace the term "subdistrict with "watershed district"; update and better describe program procedures; list general documents and non-formal names in lower case; and amend the definition of "State cost-share funds" to include "cost-share and incentive funds."

RESPONSE AND EXPLANATION OF CHANGE: The department amended sections (1), (2), (3), (4), (5), (6), (7), and (9) to address these comments.

10 CSR 70-5.020 Application and Eligibility for Funds

(1) Establishing Practice Eligibility. The commission establishes a list of eligible practices for which cost-share funds are available and affirms or modifies the list as it considers appropriate. The participating districts shall develop annual priority listings of preferred practices from the commission eligibility list upon which they will base their considerations for cost-share. Landowners are eligible for cost-share funds for only the practices designated as eligible by both the Soil and Water Districts Commission and the participating districts. No eligible practices are available to treat flood scouring problems.

(2) Application for Assistance. To be eligible for assistance from the Cost-Share Program, a landowner must apply for cost-share on forms provided by the commission. Copies of these forms are available at district offices. The district board will only act upon those applications for cost-share from landowners who have a conservation plan approved by the district for eligible practices in which implementation has not yet begun. However, governmental agencies, political subdivisions, and public institutions are excluded from participation in the Cost-Share Program.

(3) Funding Determination and Limits. It is the responsibility and duty of the district board to determine the actual dollar amount of cost-share for individual applications. In the event that the landowner wishes to construct or implement practices over and above the size or scope determined by a qualified technician to be of minimum and necessary need for soil and water conservation, the board shall provide cost-share assistance on only that part of the practice necessary for soil and water conservation purposes.

(4) Availability of Federal Funds. State cost-share assistance is available for practice units applied for but not approved by the federal program, if those additional units constitute a complete structure, conservation measure, or operation in and of themselves. State cost-share assistance may also supplement federal cost-share on an individual practice.

(5) Compliance with Applicable Law. In the implementation of any eligible practices, the landowner is responsible for assuring compliance with any applicable federal, state or local laws, ordinances, and regulations. The landowner is also responsible for obtaining all permits, licenses, or other instruments of permission required prior to the implementation of the proposed practice.

(6) Group Projects. Landowners may cooperate with other landowners in the event that the most appropriate solution to the soil and water conservation needs requires eligible practices to be located on or across property lines of different landowners. In these cases, an agreement between or among cooperating landowners must be prepared by or on behalf of the group stipulating and providing for, but not limited to, the divisions of unshared costs, maintenance, such easements as necessary to accomplish the implementation, operation, and maintenance of the practice and the sharing of rights and benefits over and above the public benefits which might accrue from the implementation of the practice. This agreement and an area conservation plan may be submitted to the district(s) within which the land included in the plans lies. Upon approval of the area conservation plan by the district(s), the individual landowners are eligible to apply for cost-share assistance under this rule. The area conservation plan may serve in lieu of the individual landowner conservation plans. All other requirements for application and cost-share assistance remain in effect.

(7) Special Projects. Upon notification of available funds for special critical-needs projects designated by the commission, the district board shall make all reasonable efforts to contact landowners within the special project area to inform them of the available cost-share funds and encourage them to cooperate in the special critical-needs projects. Landowners within the project boundaries may apply for the special cost-share assistance on practices specified as eligible by the commission. Cooperation in these special projects is entirely voluntary for landowners.

(9) Application Amendments. A copy of any amendments will be furnished to each party receiving a copy of the original application. The board shall approve each amendment required by the commission before it becomes effective. The commission will provide guidance regarding appropriate reasons for amendments.

**Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 70—Soil and Water Districts Commission
Chapter 5—State Funded Cost-Share Program**

ORDER OF RULEMAKING

By the authority vested in the Soil and Water Districts Commission under section 278.080, RSMo 2016, the commission amends a rule as follows:

10 CSR 70-5.030 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 2, 2018 (43 MoReg 1444-1445). The public comment period extended from July 2, 2018 to August 1, 2018. Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Soil and Water Conservation Program received ten (10) comments related to this rule from Mr. Ryan Britt, with the Missouri Association of Soil and Water Conservation Districts (MASWCD).

Due to the similar nature of ten (10) comments, they are grouped and addressed together.

COMMENT #1: The MASWCD made the following general comments regarding all proposed amendments to the Soil and Water Districts Commission rules in Chapter 2, 3, 4, 5, and 6: correct grammar and make sentences read better; make sentences gender neutral; make sentences more concise by adding or removing words; apply sentence structure and terms consistently in a rule or chapter; replace the term "installation" with "implementation" and the term "constructed" with "implemented"; replace the term "cost-sharing" with "cost-share"; replace the term "subdistrict" with "watershed district"; update and better describe program procedures; list general documents and non-formal names in lower case; and amend the definition of "State cost-share funds" to include "cost-share and incentive funds."

RESPONSE AND EXPLANATION OF CHANGE: The department amended sections (1), (2), (3), and (4) to address these comments.

10 CSR 70-5.030 Design, Layout and Construction of Proposed Practices; Operation and Maintenance

(1) Technical Specifications. The commission shall rely on standards and specifications for soil and water conservation practices used by the United States Department of Agriculture Natural Resources Conservation Service as the basis for determining need and practicability of the proposed practice, preparing plans and specifications, designing and laying out the practices, and certifying the proper implementation of the practices. Modifications to the standards and specifications may be considered and authorized by the commission. Practice description and specification information will be available in the district office.

(2) Inspections and Certifications. An approved technician shall inspect the work in progress to ensure that practice standards and specifications are met. Following the implementation, the technician will certify to the district that the practice was or was not properly implemented. If the district does not receive a technician's certification that the practice was properly implemented, it shall not approve any claim to the commission for payment regarding the practice.

(3) Operation and Maintenance by Landowner. The landowner shall be responsible for the operation and maintenance of all practices implemented with assistance from the Cost-Share Program and the landowner will be expected to maintain the practices in good operating condition to assure their continued effectiveness.

(4) Requests for Removal, Alteration, or Modification of Practices. The commission may grant a district's request for the removal, alteration, or modification of a practice at any time during the ten- (10-) year or expected life span, whichever is less, following payment of cost-share assistance.

**Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 70—Soil and Water Districts Commission
Chapter 5—State Funded Cost-Share Program**

ORDER OF RULEMAKING

By the authority vested in the Soil and Water Districts Commission under section 278.080, RSMo 2016, the commission amends a rule as follows:

10 CSR 70-5.040 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 2, 2018 (43 MoReg 1445). The public comment period extended from July 2, 2018 to August 1, 2018. Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Soil and Water Conservation Program received ten (10) comments related to this rule from Mr. Ryan Britt, with the Missouri Association of Soil and Water Conservation Districts (MASWCD).

Due to the similar nature of ten (10) comments, they are grouped and addressed together.

COMMENT #1: The MASWCD made the following general comments regarding all proposed amendments to the Soil and Water Districts Commission rules in Chapter 2, 3, 4, 5, and 6: correct grammar and make sentences read better; make sentences gender neutral; make sentences more concise by adding or removing words; apply sentence structure and terms consistently in a rule or chapter; replace the term "installation" with "implementation" and the term "constructed" with "implemented"; replace the term "cost-sharing" with "cost-share"; replace the term "subdistrict" with "watershed district"; update and better describe program procedures; list general documents and non-formal names in lower case; and amend the definition of "State cost-share funds" to include "cost-share and incentive funds."

RESPONSE AND EXPLANATION OF CHANGE: The department amended sections (2) and (4) to address these comments.

10 CSR 70-5.040 Cost-Share Rates and Reimbursement Procedures

(2) Eligible Costs. Eligible costs will be determined by the commission to include necessary and reasonable costs incurred by the landowner in implementing an approved practice. The costs may include, but are not limited to, machine hire or the use of the landowner's own equipment, necessary materials delivered to and used at the site, and labor required to implement the practice.

(4) Claim for Payment. The landowner is eligible for payment after the practice has been completed, certified by the technician, and approved by the district board.

Title 10—DEPARTMENT OF NATURAL RESOURCES

Division 70—Soil and Water Districts Commission

Chapter 5—State Funded Cost-Share Program

ORDER OF RULEMAKING

By the authority vested in the Soil and Water Districts Commission under section 278.080, RSMo 2016, the commission amends a rule as follows:

10 CSR 70-5.050 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 2, 2018 (43 MoReg 1445-1447). The public comment period extended from July 2, 2018 to August 1, 2018. Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Soil and Water Conservation Program received ten (10) comments related to this rule from Mr. Ryan Britt, with the Missouri Association of Soil and Water Conservation Districts (MASWCD).

Due to the similar nature of ten (10) comments, they are grouped and addressed together.

COMMENT #1: The MASWCD made the following general comments regarding all proposed amendments to the Soil and Water Districts Commission rules in Chapter 2, 3, 4, 5, and 6: correct grammar and make sentences read better; make sentences gender neutral; make sentences more concise by adding or removing words; apply sentence structure and terms consistently in a rule or chapter; replace the term "installation" with "implementation" and the term "constructed" with "implemented"; replace the term "cost-sharing" with "cost-share"; replace the term "subdistrict" with "watershed district"; update and better describe program procedures; list general documents and non-formal names in lower case; and amend the definition of "State cost-share funds" to include "cost-share and incentive funds."

RESPONSE AND EXPLANATION OF CHANGE: The department amended sections (1), (2), (3), and (4) to address these comments.

10 CSR 70-5.050 District Administration of the Cost-Share Program

(1) District Board Action on Applications. The district board shall review the cost-share assistance application and any amendments and approve or disapprove each application or amendment. The action shall be recorded in the official minutes of the district meeting and the landowners shall be notified of the action within thirty (30) days. Special circumstances may arise where district board approval for cost-share assistance is needed before the next monthly district board meeting. In those cases, the district board shall establish specific criteria by which any district board member may approve that action. Applications for cost-share assistance may be approved by the district board only when there is a sufficient unobligated fund balance to provide the estimated cost-share amount. The district board shall not approve any application for cost-share assistance in which the implementation of a project or practice has begun.

(2) District Review of Claim for Payment. Upon completion of an eligible practice, the district shall review and approve the claim for payment. If the district determines that deficiencies exist, the district shall notify the landowner and provide the landowner with a reasonable opportunity to correct the deficiencies and resubmit the claim for payment.

(3) Filing System. To provide for efficient processing of requests for cost-share assistance and for maintenance of necessary documentation of matters relating to the administration of the Cost-Share Program, the district shall develop and maintain with the assistance of the commission, a filing system which includes copies of all forms completed by the landowner and all other information considered relevant to the implementation of the eligible practices and to the cost-share assistance provided. The files shall be available for inspection by representatives of the commission and the state auditor's office.

(4) Regardless of the source of funding, each district board is authorized to deny any application or claim for payment for any program generally available through the district which is administered by the commission. The district board shall provide written notification of any denial to the applicant. The applicant may request that the commission conduct a review of the application or claim for payment. The request must be in writing and directed to the Soil and Water Districts Commission, PO Box 176, Jefferson City, MO 65102. The

request must be received by the commission no later than thirty (30) days from the date the applicant received the denial notification from the district board. The applicant, upon request, may appear before the commission in person, by a representative, or in writing. The commission shall schedule the review of the application at a commission meeting within one hundred twenty (120) days of the district board's denial. The commission shall give the applicant at least thirty (30) days written notice of the meeting when the commission will review the application.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 70—Soil and Water Districts Commission
Chapter 5—State Funded Cost-Share Program

ORDER OF RULEMAKING

By the authority vested in the Soil and Water Districts Commission under section 278.080, RSMo 2016, the commission amends a rule as follows:

10 CSR 70-5.060 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 2, 2018 (43 MoReg 1447-1448). The public comment period extended from July 2, 2018 to August 1, 2018. Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Soil and Water Conservation Program received ten (10) comments related to this rule from Mr. Ryan Britt, with the Missouri Association of Soil and Water Conservation Districts (MASWCD).

Due to the similar nature of ten (10) comments, they are grouped and addressed together.

COMMENT #1: The MASWCD made the following general comments regarding all proposed amendments to the Soil and Water Districts Commission rules in Chapter 2, 3, 4, 5, and 6: correct grammar and make sentences read better; make sentences gender neutral; make sentences more concise by adding or removing words; apply sentence structure and terms consistently in a rule or chapter; replace the term "installation" with "implementation" and the term "constructed" with "implemented"; replace the term "cost-sharing" with "cost-share"; replace the term "subdistrict" with "watershed district"; update and better describe program procedures; list general documents and non-formal names in lower case; and amend the definition of "State cost-share funds" to include "cost-share and incentive funds."

RESPONSE AND EXPLANATION OF CHANGE: The department amended sections (1), (2), and (5) to address these comments.

10 CSR 70-5.060 Commission Administration of the Cost-Share Program

(1) Forms. The commission shall develop and make available to participating districts, forms necessary for district administration, and prepare and keep updated guidance for district use in assisting with administration of the Cost-Share Program.

(2) Commission Review of Claims for Payment. Upon receipt of a district-approved claim for payment, a commission representative reviews the claim and supporting documentation. If the claim is determined to be complete and properly documented, payment will be made by the Office of Administration to the landowner.

(5) Violations of Cost-Share Assistance Agreement. In the event the commission is notified of an alleged violation of the cost-share assistance agreement, a representative of the commission, or a representative of the district, or both, shall investigate the alleged violation and report the results of the investigation to the commission. If, following the investigation, it appears as though a violation has occurred, the district board shall notify the landowner by certified mail, return receipt requested, and demand repayment of the appropriate amount to the Cost-Share Program within thirty (30) days after receipt of the demand for repayment. Within that thirty- (30-) day period, the landowner may request the commission review the demand for repayment. The request for a review must be in writing. The review shall be conducted at a commission meeting, allowing adequate opportunity for the landowner to present arguments in support of the claim. The landowner's arguments may be presented by the landowner, by a representative, or in writing. If, following the review, the commission determines that no violation has occurred or that extenuating circumstances justify the landowner's position, the demand for repayment shall be withdrawn and the commission shall notify the landowner of its decision. If, however, following the review, the commission determines the violation did occur, it shall notify the landowner by certified mail, return receipt requested, and renew the demand for repayment. If the repayment is not received within thirty (30) days of receipt of the commission's request for repayment or if all deficiencies are not corrected at the landowner's expense within the time specified by the commission, the commission may refer the matter to the Office of the Attorney General for recovery of the state cost-share funds.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 70—Soil and Water Districts Commission
Chapter 6—Tax Levy Referendums

ORDER OF RULEMAKING

By the authority vested in the Soil and Water Districts Commission under section 278.080, RSMo 2016, the commission amends a rule as follows:

10 CSR 70-6.010 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 2, 2018 (43 MoReg 1448). The public comment period extended from July 2, 2018 to August 1, 2018. Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Soil and Water Conservation Program received ten (10) general comments for all five (5) chapters related to the Soil and Water Districts Commission's rules from Mr. Ryan Britt, with the Missouri Association of Soil and Water Conservation Districts (MASWCD).

Due to similarity in nature of the comments, some of the comments are grouped together.

COMMENT #1: The MASWCD made the following general comments regarding all proposed amendments to the Soil and Water Districts Commission rules in Chapter 2, 3, 4, 5, and 6: correct grammar and make sentences read better; make sentences gender neutral; make sentences more concise by adding or removing words; apply sentence structure and terms consistently in a rule or chapter; replace the term "installation" with "implementation" and the term "constructed" with "implemented"; replace the term "cost-sharing" with "cost-share"; update and better describe program procedures;

list general documents and non-formal names in lower case; and amend the definition of “State cost-share funds” to include “cost-share and incentive funds.”

RESPONSE AND EXPLANATION OF CHANGE: The department amended section (3) and subsections (4)(D) and (5)(A) to address the general comments.

COMMENT #2: The MASWCD commented to replace the term “subdistrict” with “watershed district.”

RESPONSE: This language was in the proposed language during the public notice period. No additional change was made.

10 CSR 70-6.010 Watershed District Tax Levy Referendums

(3) Each landowner is eligible to vote at a designated polling place. If a landowner is unable to personally vote, such landowner may give power of attorney to a taxpaying citizen of the watershed district to represent the landowner. The power of attorney authorization form must be given to the referendum judges.

(4) The watershed district trustees will—

(D) Prepare ballots, tally sheets, voter registration sheets, and an envelope for storing cast ballots and deliver them to the judges. Ballots shall state the amount of the proposed tax and whether it is an organization tax or a tax for construction, repair, alteration, maintenance, and operation;

(5) The referendum judges will—

(A) Be present during the polling period and for counting the votes. If any election judge is not present at the time for opening the polls, the judges present shall select a landowner of the watershed district to serve as a judge and give this person the necessary instructions. A majority of the election judges shall determine, in accordance with section (3), the qualifications of a voter as presented at the polls;

Title 10—DEPARTMENT OF NATURAL RESOURCES Division 130—State Environmental Improvement and Energy Resources Authority Chapter 1—Applications

ORDER OF RULEMAKING

By the authority vested in the State Environmental Improvement and Energy Resources Authority under section 260.035(1), RSMo 2016, the State Environmental Improvement and Energy Resources Authority withdraws a proposed amendment as follows:

10 CSR 130-1.010 Definitions is withdrawn.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 1, 2018 (43 MoReg 2308–2309). This proposed amendment is withdrawn.

SUMMARY OF COMMENTS: The State Environmental Improvement and Energy Resources Authority received no comments on this proposed amendment; however, a link to the *Missouri Register* containing the proposed amendment was not provided on the agency’s website.

RESPONSE: The proposed amendment is being withdrawn to allow the State Environmental Improvement and Energy Resources Authority to provide a link on its web site to the proposed amendment when refiled.

Title 10—DEPARTMENT OF NATURAL RESOURCES Division 130—State Environmental Improvement and Energy Resources Authority Chapter 1—Applications

ORDER OF RULEMAKING

By the authority vested in the State Environmental Improvement and Energy Resources Authority under section 260.035(1) RSMo 2016, the State Environmental Improvement and Energy Resources Authority withdraws a proposed amendment as follows:

10 CSR 130-1.020 Applications Forms and Fees is withdrawn.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 1, 2018 (43 MoReg 2309–2311). This proposed amendment is withdrawn.

SUMMARY OF COMMENTS: The State Environmental Improvement and Energy Resources Authority received no comments on this proposed amendment; however, a link to the *Missouri Register* containing the proposed amendment was not provided on the agency’s website.

RESPONSE: The proposed amendment is being withdrawn to allow the State Environmental Improvement and Energy Resources Authority to provide a link on its web site to the proposed amendment when refiled.

Title 11—DEPARTMENT OF PUBLIC SAFETY Division 45—Missouri Gaming Commission Chapter 7—Security and Surveillance

ORDER OF RULEMAKING

By the authority vested in the Missouri Gaming Commission under section 313.805, RSMo 2016, the commission rescinds a rule as follows:

11 CSR 45-7.090 Dock Site Commission Facility is rescinded.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on July 2, 2018 (43 MoReg 1448–1449). No changes have been made to the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: A public hearing was held on this proposed rescission on July 31, 2018. No one commented on this proposed rescission at the public hearing, and no written comments were received.

Title 11—DEPARTMENT OF PUBLIC SAFETY Division 45—Missouri Gaming Commission Chapter 10—Licensee’s Responsibilities

ORDER OF RULEMAKING

By the authority vested in the Missouri Gaming Commission under section 313.805, RSMo 2016, the commission amends a rule as follows:

11 CSR 45-10.020 Licensee’s and Applicant’s Duty to Disclose Changes in Information is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 2, 2018 (43 MoReg 1449). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: A public hearing was held on this proposed amendment on July 31, 2018. No one commented on this proposed amendment at the public hearing, and no written comments were received.

**Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 40—Fantasy Sports Contests**

ORDER OF RULEMAKING

By the authority vested in the Missouri Gaming Commission under section 313.955, RSMo 2016, the commission amends a rule as follows:

11 CSR 45-40.060 Cash Reserve and Segregated Account Requirements **is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 2, 2018 (43 MoReg 1449–1450). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: A public hearing was held on this proposed amendment on July 31, 2018. No one commented on this proposed amendment at the public hearing, and no written comments were received.

**Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 15—Hospital Program**

ORDER OF RULEMAKING

By the authority vested in the Department of Social Services, MO HealthNet Division under sections 208.153, 208.201, and 660.017, RSMo 2016, the division amends a rule as follows:

13 CSR 70-15.010 Inpatient Hospital Services Reimbursement Plan; Outpatient Hospital Services Reimbursement Methodology **is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 1, 2018 (43 MoReg 2311–2314). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 15—Hospital Program**

ORDER OF RULEMAKING

By the authority vested in the Department of Social Services, MO HealthNet Division under sections 208.201, 208.455, and 660.017, RSMo 2016, the division amends a rule as follows:

13 CSR 70-15.110 Federal Reimbursement Allowance (FRA) **is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 1, 2018 (43 MoReg 2315–2318). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF INSURANCE,
FINANCIAL INSTITUTIONS AND PROFESSIONAL
REGISTRATION**

**Division 2150—State Board of Registration for the
Healing Arts
Chapter 3—Licensing of Physical Therapists and
Physical Therapist Assistants**

ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under section 334.125, RSMo 2016, the board amends a rule as follows:

20 CSR 2150-3.080 Physical Therapists Licensure Fees **is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 15, 2018 (43 MoReg 2469–2471). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF INSURANCE,
FINANCIAL INSTITUTIONS AND PROFESSIONAL
REGISTRATION**

**Division 2150—State Board of Registration for the
Healing Arts
Chapter 3—Licensing of Physical Therapists and
Physical Therapist Assistants**

ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under section 334.125, RSMo 2016, the board amends a rule as follows:

20 CSR 2150-3.170 Physical Therapist Assistant Licensure Fees **is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 15, 2018 (43 MoReg 2472–2474). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF INSURANCE,
FINANCIAL INSTITUTIONS AND PROFESSIONAL
REGISTRATION**

**Division 2150—State Board of Registration for the
Healing Arts**

**Chapter 3—Licensing of Physical Therapists and
Physical Therapist Assistants**

ORDER OF RULEMAKING

By the authority vested in the State Board of Registration for the Healing Arts under section 334.125, RSMo 2016, the board adopts a rule as follows:

20 CSR 2150-3.300 Physical Therapy Compact Rules is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on August 15, 2018 (43 MoReg 2475). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

This section may contain notice of hearings, correction notices, public information notices, rule action notices, statements of actual costs, and other items required to be published in the *Missouri Register* by law.

Salary Schedule Maintained pursuant to Section 105.005, RSMo

<u>Office</u>	<u>FY 2019 Salary</u>
<u>Elected Officials</u>	
Governor	\$133,821
Lt. Governor	86,484
Attorney General	116,437
Secretary of State	107,746
State Treasurer	107,746
State Auditor	107,746
<u>General Assembly</u>	
Senator	35,915
Representative	35,915
Speaker of House	38,415
President Pro Tem of Senate	38,415
Speaker Pro Tem of the House	37,415
Majority Floor Leader of House	37,415
Majority Floor Leader of Senate	37,415
Minority Floor Leader of House	37,415
Minority Floor Leader of Senate	37,415
<u>State Tax Commissioners**</u>	108,756
<u>Administrative Hearing Commissioners**</u>	106,039
<u>Labor and Industrial Relations</u>	
<u>Commissioners**</u>	108,759
<u>Division of Workers' Compensation</u>	
Chief Legal Counsel *	113,754
Administrative Law Judge *	125,724
Administrative Law Judge in Charge *	130,724
Director, Division of Workers' Compensation*	132,724
<u>Public Service Commissioners**</u>	108,759

FY 2019

<u>Statutory Department Directors**</u>	\$86,688 - \$147,408
Administration, Agriculture, Corrections, Economic Development, Labor and Industrial Relations, Natural Resources, Public Safety, Revenue, and Social Services	
<u>Probation and Parole**</u>	
Chairman	\$66,624 - \$106,632
Board Members	\$50,112 - \$80,184

**Division of Workers' Compensation statutory salaries are tied to those of Associate Circuit Judges and are subject to appropriation.*

***As per appropriated pay plan beginning January 1, 2019, these salaries and the salaries of other state employees generally will increase by 1% (or \$700 for salaries less than \$70,000).*

Salary Schedule Maintained pursuant to Section 476.405, RSMo

	<u>FY 2019 Salary</u>
<u>Supreme Court</u>	
Chief Justice	\$184,230
Judges	176,157
<u>Court of Appeals</u>	
Judges	161,038
<u>Circuit Court</u>	
Circuit Court Judges	151,840
Associate Circuit Judges	139,693
<u>Juvenile Officers</u>	
Juvenile Officer	49,062
Chief Deputy Juvenile Officer	42,721
Deputy Juvenile Officer Class 1	38,121
Deputy Juvenile Officer Class 2	24,759
Deputy Juvenile Officer Class 3	31,742
<u>Court Reporters</u>	58,322
<u>Probate Commissioner *</u>	149,723
<u>Deputy Probate Commissioner *</u>	137,745
<u>Family Court Commissioner *</u>	137,745
<u>Circuit Clerk</u>	
1st Class Counties	71,846
St. Louis City	115,850
Jackson, Jasper & Cape Girardeau	76,145
2nd & 4th Class Counties	64,800
3rd Class Counties	56,752
Marion-Hannibal & Palmyra	63,798
Randolph	61,981

As per appropriated pay plan beginning January 1, 2019, the salaries of other state employees generally will increase by 1% (or \$700 for salaries less than \$70,000).

**Salaries are tied to those of Circuit and Associate Circuit Judges, subject to appropriation.*

**Missouri Executive Pay Plan
Fiscal Year 2019***

Executive Level	Minimum	Maximum
I	\$86,688	\$147,408
II	\$73,776	\$125,448
III	\$66,624	\$106,632
IV	\$50,112	\$80,184

*As per appropriated pay plan beginning January 1, 2019, these salaries and the salaries of other state employees generally will increase by 1% (or \$700 for salaries less than \$70,000).

**Title 5—DEPARTMENT OF ELEMENTARY AND
SECONDARY EDUCATION**

Division 20—Division of Learning Services
*[Chapter 600—Office of Early and Extended
Learning]*
Chapter 100—Office of Quality Schools

IN ADDITION

As a result of an internal reorganization, the Department of Elementary and Secondary Education (department) is transferring from the Division of Learning Services, Office of Early and Extended Learning to the Division of Learning Services, Office of Quality Schools. Effective September 18, 2018, the following rules are transferred to the Division of Learning Services, Office of Quality Schools.

5 CSR 20-/600.120/100.300 Instruction for Prekindergarten

**5 CSR 20-/600.130/100.310 General Provisions Governing
Programs Authorized Under Early Childhood Development,
Education, and Care**

5 CSR 20-/600.140/100.320 Prekindergarten Program Standards

**Title 19—DEPARTMENT OF HEALTH AND
SENIOR SERVICES**

**Division 60—Missouri Health Facilities Review
Committee**
Chapter 50—Certificate of Need Program

**NOTIFICATION OF REVIEW:
APPLICATION REVIEW SCHEDULE**

The Missouri Health Facilities Review Committee has initiated review of the CON application listed below. A decision is tentatively scheduled for December 27, 2018. This application is available for public inspection at the address shown below.

Date Filed

Project Number: Project Name
City (County)
Cost, Description

11/13/2018

#5658 HT: Mercy Hospital St. Louis
St. Louis (St. Louis County)
\$1,782,845, Replace angiography system

Any person wishing to request a public hearing for the purpose of commenting on this application must submit a written request to this effect, which must be received by December 14, 2018. All written requests and comments should be sent to—

Chairman
Missouri Health Facilities Review Committee
c/o Certificate of Need Program
3418 Knipp Drive, Suite F
PO Box 570
Jefferson City, MO 65102
For additional information contact Karla Houchins at karla.houchins@health.mo.gov.

Missouri Department of Revenue

Run Date : 10/18/2018 4:16:12 PM

E10130

Taxation Division

Show Secretary of State Cover: Yes

Construction Transient Employer Listing

The following is a list of all construction contractors performing work on construction projects in Missouri who are known by the Department of Revenue to be transient employers pursuant to Section 285.230, RSMo. This list is provided as a guideline to assist public bodies with their responsibilities under this section that states, "any county, city, town, village or any other political subdivision which requires a building permit for a person to perform certain construction projects shall require a transient employer to show proof that the employer has been issued a tax clearance and has filed a financial assurance instrument as required by Section 285.230 before such entity issues a building permit to the transient employer."

Contractor Name	Street Address	Street Address 2	City	State	Zip Code
KANSAS DUSTROL INC	PO BOX 308		TOWANDA	KS	67144-0308
X-TRA LIGHT MANUFACTURING LP	8812 FREY RD		HOUSTON	TX	77034-3502
2 POINT CONSTRUCTION CO LLC	7252 W FRONTAGE RD		SHAWNEE	KS	66203-4638
4MC CORPORATION	8040 JORDAN RD		OAKLEY	IL	62501-6999
A & B PROCESS SYSTEMS CORP	PO BOX 86		STRATFORD	WI	54484-0086
A & K CONSTRUCTION SERVICES INC	100 CALLOWAY CT		PADUCAH	KY	42001-9035
A EPSTEIN & SONS INTERNATIONAL INC	600 W FULTON ST STE 800		CHICAGO	IL	60661-1254
A I INTERNATIONAL INC	8055A NATIONAL TPKE		LOUISVILLE	KY	40214-5201
A LUSKER MASONRY LLC	452 S 210TH ST		FRONTENAC	KS	66763-8407
A ROCK CONSTRUCTION CO INC	316 IONE ST		GREENWOOD	MS	38930-3712
A+ COMMUNICATIONS & SECURITY LLC	5609 NE 22ND ST		DES MOINES	IA	50313-2531
AAPCO SOUTHEAST	506 WEBB RD		CONCORD	NC	28025-9072
ABAT BUILDERS INC	10700 W HIGGINS RD STE 350		ROSEMONT	IL	60018-3723
ABATEPRO INC	PO BOX 674		EDWARDSVILLE	IL	62025-0674

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EI0130

Show Secretary of State Cover: Yes

Missouri Department of Revenue

Taxation Division

Construction Transient Employer Listing

Contractor Name	Street Address	Street Address 2	City	State	Zip Code
ABSOLUTE CONSTRUCTION INC	954 KENNEDY AVE		SCHERERVILLE	IN	46375-7100
ACADEMY ROOFING & SHEET METAL OF THE MIDWEST INC	6361 NE 14TH ST		DES MOINES	IA	50313-1212
ACCESS RIGGING LLC	514 ANCLOTE RD		TARPON SPGS	FL	34689-6701
ACCESSIBILITY REMODELING LLC	6025 METCALF LN # 320		SHAWNEE MSN	KS	66202-2339
ACE AIR CONDITIONING INC	2985 ENTERPRISE RD STE A		DEBARY	FL	32713-2710
ACE REFRIGERATION OF IOWA INC	6440 6TH ST SW		CEDAR RAPIDS	IA	52404-4733
ACE SIGN COMPANY	2540 S 1ST ST		SPRINGFIELD	IL	62704-4700
ACE/AVANT CONCRETE CONSTRUCTION CO INC	PO BOX 14006		ARCHDALE	NC	27263-7006
ACRONYM MEDIA INC	350 5TH AVE STE 6500		NEW YORK	NY	10118-6500
ADVANCE ELECTRIC INC	353 N INDIANA AVE		WICHITA	KS	67214-4034
ADVANCED CABLING SYSTEMS LLC	4950 NORTHSHORE LN		N LITTLE ROCK	AR	72118-5321
ADVANCED DEVELOPMENT INC	2426 ADVANCED BUS CTR DR		COLUMBUS	OH	43228-9042
ADVANCED EROSION SOLUTIONS LLC	15257 S KEELER ST		OLATHE	KS	66062-2714
ADVANTAGE BLASTING & DEMOLITION LLC	2900 SOUTH NOAH DRILVE		SAXONBURG	PA	16056
AE MFG INC	PO BOX 9457		TULSA	OK	74157-0457
AES MECHANICAL SERVICES GROUP INC	PO BOX 780115		TALLASSEE	AL	36078-0014
AG PROPERTY SOLUTIONS	PO BOX 96		EMMETSBURG	IA	50536-0096

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Missouri Department of Revenue

Taxation Division

EI0130

Show Secretary of State Cover: Yes

Construction Transient Employer Listing

Contractor Name	Street Address	Street Address 2	City	State	Zip Code
AH BECK FOUNDATION CO INC	5123 BLANCO RD		SAN ANTONIO	TX	78216-7098
AHRS CONSTRUCTION INC	533 RAILROAD ST		BERN	KS	66408-8006
AIC INSULATION COMPANY INC	19925 W 161ST ST STE B		OLATHE	KS	66062-2788
AIR-CURE INCORPORATED	8501 EVERGREEN BLVD NW		MINNEAPOLIS	MN	55433-6035
ALBERTINE COMPANY LLC	2176 WEST ST STE 207		GERMANTOWN	TN	38138-3859
ALDRIDGE ELECTRIC INC	844 E ROCKLAND RD		LIBERTYVILLE	IL	60048-3358
ALL AMERICAN TRACK INC	PO BOX 186		ASH FORK	AZ	86320-0186
ALL PURPOSE ERECTORS INC	1112 STARLIFTER DR		LEBANON	IL	62254-2724
ALL SERVICE CONTRACTING CORP	2024 E DAMON AVE		DECATUR	IL	62526-4749
ALL STAR ELECTRIC NA LLC	PO BOX 450879		GROVE	OK	74345-0879
ALLENTECH INC	6350 HEDGEWOOD DR UNIT 100		ALLENTOWN	PA	18106-9257
ALLIANCE GLAZING TECHNOLOGIES, INC.	646 FORESTWOOD DR		ROMEDEVILLE	IL	60446-1378
ALLIANCE RETAIL CONSTRUCTION INC	6000 CLARK CENTER AVE		SARASOTA	FL	34238-2716
ALPHA MECHANICAL SERVICE INC	7200 DISTRIBUTION DR		LOUISVILLE	KY	40258-2827
AMC INSPECTION & LOCATORS	PO BOX 592		BEEBE	AR	72012-0592
AMERICAN BRIDGE COMPANY	1000 AMERICAN BRIDGE WAY		CORAOPOLIS	PA	15108-1266
AMERICAN COATINGS	612 W IRIS DR		NASHVILLE	TN	37204-3121
AMERICAN GLASS INC	4600 W 21ST ST		TULSA	OK	74107-3455

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AMERICAN HYDRO CORPORATION	PO BOX 3628		YORK	PA	17402-0136
AMERICAN LIFT & SIGN SERVICE COMPANY	6958 N 97TH CIR		OMAHA	NE	68122-1060
AMERICAN PRESERVATION BUILDERS LLC	8111 ROCKSIDE RD STE 101		CLEVELAND	OH	44125-6130
AMERICAN REMODELING CONTRACTORS INC	776 N WEST ST		WICHITA	KS	67203-1235
AMERICAN ROOFING	2500 S 2ND ST		LEAVENWORTH	KS	66048-4542
AMERICAN SEALANTS INC	2483 RIVERSIDE PKWY		GRAND JCT	CO	81505-1319
AMERICAN WELDING AND GAS INC	4900 FALLS OF NEUSE RD STE 150		RALEIGH	NC	27609-5490
AMES CONSTRUCTION INC	14420 COUNTY ROAD 5		BURNSVILLE	MN	55306-6997
ANCHOR SIGN INC	PO BOX 22737		CHARLESTON	SC	29413-2737
ANTEX ROOFING COMPANY INC	1360 HUGH RD		HOUSTON	TX	77067-1598
ANTIGO CONSTRUCTION INC	PO BOX 12		ANTIGO	WI	54409-0012
AOI CORPORATION	8801 S 137TH CIR		OMAHA	NE	68138-3455
AP PROFESSIONALS OF PHOENIX LLC	350 LINDEN OAKS		ROCHESTER	NY	14625-2807
APACHE INDUSTRIAL UNITED INC	250 ASSAY ST STE 500		HOUSTON	TX	77044-3507
APPLE ELECTRIC INTEGRATED SOLUTIONS INC	PO BOX 998		LOUISBURG	KS	66053-0998
APPLIED POLYMERIC INC	131 SAINT JAMES WAY		MOUNT AIRY	NC	27030-6068
ARACREBS1 LLC	PO BOX 1670		SPRINGDALE	AR	72765-1670

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ARCHER WESTERN CONTRACTORS LLC	PAYROLL 929 W ADAMS ST		CHICAGO	IL	60607
ARCHWALL LLC	PO BOX 38		STRAWBERRY PT	IA	52076-0038
ARCO DESIGN BUILD MIDWEST INC	900 N ROCK HILL RD		SAINT LOUIS	MO	63119-1315
ARDENT SERVICES	170 NEW CAMELLIA BLVD		COVINGTON	LA	70433-7819
ARISTEO CONSTRUCTION COMPANY	12811 FARMINGTON RD		LIVONIA	MI	48150-1607
ARISTEO INSTALLATION, LLC	12811 FARMINGTON RD		LIVONIA	MI	48150-1607
ARMI CONTRACTORS INC	1860 E PUMP STATION RD		FAYETTEVILLE	AR	72701-7294
ARNDT ENTERPRISES INC	2579 195TH ST		DE WITT	IA	52742-9114
ARNOLDS CUSTOM SEEDING LLC	4626 WCR 65		KEENESBURG	CO	80643
ARROW SIGNS & OUTDOOR ADVERTISING INC	4545 N ALBY STREET		ALTON	IL	62002
ARVOS LJUNGSTROM LLC	3020 TRUAX RD		WELLSVILLE	NY	14895-9531
ASA CARLTON INC	5224 PALMERO CT # 1		BUFORD	GA	30518-5868
ASPHALT STONE COMPANY	PO BOX 1060		JACKSONVILLE	IL	62651-1060
ASSOCIATED FIRE PROTECTION	4905 S 97TH ST		OMAHA	NE	68127-2202
ATLANTIC FIXTURE INSTALLATIONS INC	1615 ROBIN CIR STE H		FOREST HILL	MD	21050-3058
ATLAS TRENCHLESS LLC	PO BOX 488		ROCKVILLE	MN	56369-0488
ATWELL LLC	2 TOWNE SQ STE 700		SOUTHFIELD	MI	48076-3737
ATWOOD ELECTRIC INC	PO BOX 311		SIGOURNEY	IA	52591-0311
AUDIO VISUAL INNOVATIONS INC	6301 BENJAMIN RD STE 101		TAMPA	FL	33634-5115

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AYARS & AYARS INC	2436 N 48TH ST		LINCOLN	NE	68504-3627
B & M WEST CONSTRUCTION OF TEXAS LP	2571 HWY 60		BARTOW	FL	33830-8872
B & S STEEL CO., LLC	1604 S AVE		MORNING SUN	IA	52640-9698
B + T GROUP HOLDINGS INC	1717 S BOULDER AVE STE 300		TULSA	OK	74119-4843
B D WELCH CONSTRUCTION LLC	120 INDUSTRIAL STATION RD		STEELE	AL	35987-0017
B&E ELECTRICAL INC	1843 ROYLE RD		SUMMERVILLE	SC	29486-1779
BACON FARMER WORKMAN ENGINEERING & TESTING INC	500 S 17TH ST		PADUCAH	KY	42003-2819
BAILEY CONSTRUCTION AND CONSULTING LLC	2200 N RODNEY PARHAM RD STE 206		LITTLE ROCK	AR	72212-4155
BAJA CONSTRUCTION CO INC	223 FOSTER ST		MARTINEZ	CA	94553-1029
BANK HOLDINGS LLC	9111 W 131ST PL		OVERLAND PARK	KS	66213-4602
BARRIER TECHNOLOGIES LLC	8245 NIEMAN RD		LENEXA	KS	66214-1508
BARTON ELECTRIC CONTRACTING INC	247 STATE ROUTE 160		TRENTON	IL	62293-4667
BAUER DESIGN BUILD LLC	14030 21ST AVE N		PLYMOUTH	MN	55447-4686
BAY INSULATION CONTRACTING INC	PO BOX 9229		GREEN BAY	WI	54308-9229
BAZIN SAWING & DRILLING LLC	30790 SWITZER RD		LOUISBURG	KS	66053-5903
BEL O COOLING & HEATING INC	90 WHITEHALL DR		O FALLON	IL	62269-2670

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BERBERICH TRAHAN & CO PA	3630 SW BURLINGAME RD		TOPEKA	KS	66611-2092
BERG PAINTING LLC	118 PEAVEY CIR		CHASKA	MN	55318-2347
BEST BUILDERS OF ILLINOIS	717 N CLINTON ST		LITCHFIELD	IL	62056-1024
BEST PLUMBING & HEATING	421 N SECTION LINE RD		SCAMMON	KS	66773-6201
BETHALTO GLASS INC	PO BOX 30		BETHALTO	IL	62010-0030
BETTIS ASPHALT & CONSTRUCTION INC	PO BOX 1694		TOPEKA	KS	66601-1694
BG ZYCRON STAFFING	5850 GRANITE PKWY STE 730		PLANO	TX	75024-0035
BIERMAN CONTRACTING INC	PO BOX 1887		COLUMBUS	NE	68602-1887
BIGGE CRANE AND RIGGING CO	10700 BIGGE ST		SAN LEANDRO	CA	94577-1032
BINGHAM SAND & GRAVEL CO INC	PO BOX 660		BAXTER SPGS	KS	66713-0660
BIRDAIR INC	65 LAWRENCE BELL DR STE 100		AMHERST	NY	14221-7094
BKM CONSTRUCTION LLC	501 S 5TH ST		LEAVENWORTH	KS	66048-2610
BLAHNIK CONSTRUCTION COMPANY	150 50TH AVENUE DR SW		CEDAR RAPIDS	IA	52404-5038
BLANKENSHIP CONSTRUCTION CO	1824 IL ROUTE 140		MULBERRY GRV	IL	62262-3303
BLD SERVICES LLC	2424 TYLER ST		KENNER	LA	70062-4845
BLUE SKY CONSTRUCTION OF IDAHO LLC	2365 E COLUMBIA RD		MERIDIAN	ID	83642-7211
BLUE STREAK CABLE & TELECOMMUNICATIONS LLC	8200 NW 41ST ST STE 318		DORAL	FL	33166-6206
BLUESTONE LLC	220 N SMITH ST STE 420		PALATINE	IL	60067-2477

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BLUEWATER CONSTRUCTORS INC	PO BOX 55482		HOUSTON	TX	77255-5482
BLUSKY RESTORATION CONTRACTORS INC	9767 E EASTER AVE		CENTENNIAL	CO	80112-3747
BOB BERGKAMP CONSTRUCTION CO INC	3709 S WEST ST		WICHITA	KS	67217-3898
BOB FLORENCE CONTRACTOR INC	PO BOX 5258		TOPEKA	KS	66605-0258
BOB MYER BUILDERS INC	147 NW NORTH SHORE DR		LAKE WAUKOMIS	MO	64151-1459
BODINE ELECTRIC OF DECATUR	PO BOX 976		DECATUR	IL	62525-1810
BORTON CONSTRUCTION INC	2 COPELAND AVE STE 201		LA CROSSE	WI	54603-3419
BORTON LC	PO BOX 2108		HUTCHINSON	KS	67504-2108
BOUMA CONSTRUCTION INC	4101 ROGER B CHAFFEE MEM DR SE		GRAND RAPIDS	MI	49548-3443
BRADSHAW CONSTRUCTION CORPORATION MARYLAND	175 W LIBERTY RD		ELDERSBURG	MD	21784-9381
BRANCH BUILDING GROUP LLC	813 COLUMBIA AVE STE B		FRANKLIN	TN	37064-8222
BRANTLEY CONSTRUCTION LLC	7227 W 162ND TER		STILWELL	KS	66085-8238
BRAYMAN CONSTRUCTION CORPORATION	1000 JOHN ROEBLING WAY		SAXONBURG	PA	16056-9778
BRENT ELECTRIC CO INC	5840 S MEMORIAL DR STE 214		TULSA	OK	74145-9081
BREWSTER COMPANIES INC	6321 E MAIN ST		MARYVILLE	IL	62062-2014
BRINK CONSTRUCTORS INC	2950 N PLAZA DR		RAPID CITY	SD	57702-9323
BRINK READY MIX	4400 N 24TH ST		QUINCY	IL	62305-7775

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BRITT AASEBY CONSTRUCTION INC	3025 HARBOR LN N STE 410		PLYMOUTH	MN	55447-5142
BROCK SERVICES LLC	PO BOX 306		BEAUMONT	TX	77704-0306
BROOKS DIRECTIONAL DRILLING LLC	24531 102ND DR		BURDEN	KS	67019-9202
BROOKS ELECTRICAL	1107 N 1712 RD		LAWRENCE	KS	66049-9714
BROWN & ROOT INDUSTRIAL SERVICES LLC	601 JEFFERSON ST		HOUSTON	TX	77002-7900
BROWN CHURCH CONSTRUCTION INC	1616 30TH AVE		KEARNEY	NE	68845-1509
BROWN TANK LLC	6995 55TH ST N STE A		SAINT PAUL	MN	55128-1726
BRUCE DAVIS CONSTRUCTION LLC	PO BOX 1924		EMPORIA	KS	66801-1924
BRUMIT SERVICES INC	616 PAULA DR APT B		WATERLOO	IL	62298-1881
BRYAN-OHLMEIER CONST INC	911 N PEARL ST		PAOLA	KS	66071-1139
BUEHNER CONSTRUCTION INC	3158 S MAIN ST		SALT LAKE CTY	UT	84115-3750
BUFFALO GAP INSTRUMENTATION & ELECTRICAL COMPANY I	2532 AYMOND ST		EUNICE	LA	70535-6843
BUILD IT RIGHT LLC	PO BOX 372		BELEN	NM	87002-0372
BUILDING CRAFTS INC	2 ROSEWOOD DR		WILDER	KY	41076-9007
BULLEY & ANDREWS MASONRY RESTORATION LLC	1755 W ARMITAGE AVE		CHICAGO	IL	60622-1189
BUSH TURF INC	6800 78TH AVE W		MILAN	IL	61264-4146
BUTT CONSTRUCTION COMPANY INCORPORATED	3858 GERMANY LN		DAYTON	OH	45431-1607

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BYUS CONSTRUCTION INC	16602 CRAWFORD AVE		MARKHAM	IL	60428-5378
C & A SCALE SERVICE, INC.	25300 OLD LINCOLN HWY		HONEY CREEK	IA	51542-4236
C & C DEMOLITION	1226 ILLINOIS ST		DES MOINES	IA	50314-3106
C D L ELECTRIC COMPANY INC	1308 N WALNUT ST		PITTSBURG	KS	66762-3034
C JUENGEL INC	660 S MAIN ST		BREESE	IL	62230-2028
CACHE VALLEY ELECTRIC COMPANY	875 N 1000 W		LOGAN	UT	84321-7800
CADY AQUASTORE	920 W PRAIRIE DR STE G		SYCAMORE	IL	60178-3123
CAHILL CONSTRUCTION INC	5233 BETHEL CENTER MALL		COLUMBUS	OH	43220-2085
CANNON UTILITY SERVICES LLC	1320 E STATE ROUTE 15		BELLEVILLE	IL	62220-4803
CAPEHART & CAPEHART BUILDERS INC	PO BOX 846		SALLISAW	OK	74955-0846
CAPITAL INSULATION INC	2714 NW TOPEKA BLVD STE 106		TOPEKA	KS	66617-1148
CAPITOL CONSTRUCTION SERVICES OF INDIANA INC	11051 VILLAGE SQUARE LN		FISHERS	IN	46038-4552
CARDINAL INTERNATIONAL GROOVING & GRINDING LLC	PO BOX 450		CONSHOHOCKEN	PA	19428-0450
CARPORT STRUCTURES CORPORATION	1825 METAMORA RD		OXFORD	MI	48371-2419
CAS CONSTRUCTORS LLC	3500 SW FAIRLAWN RD STE 200		TOPEKA	KS	66614-3979
CASE FOUNDATION COMPANY	PO BOX 40		ROSELLE	IL	60172
CASEY INDUSTRIAL INC	1400 W 122ND AVE STE 200		WESTMINSTER	CO	80234-3440
CASH DEPOT LTD	1740 COFRIN DR STE 2		GREEN BAY	WI	54302-2086

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CATALYST AIR MANAGEMENT INC	2505 BYINGTON SOLWAY RD		KNOXVILLE	TN	37931-3854
CB RECOVERY GROUP INC	1821 WALDEN OFFICE SQ STE 395		SCHAUMBURG	IL	60173-4285
CCC GROUP INC	PO BOX 200350		SAN ANTONIO	TX	78220-0350
CELLSITE SOLUTIONS LLC	1720 I AVE NE		CEDAR RAPIDS	IA	52402-5205
CEMROCK LANDSCAPES INC	4790 S JULIAN AVE		TUCSON	AZ	85714-2123
CENTER LINE ELECTRIC, INC.	PO BOX 1047		BELLS	TN	38006-1047
CENTRIC SECURITY & AUTOMATION INC	103 LANTER CT		COLLINSVILLE	IL	62234-6124
CENTURY FIRE PROTECTION LLC	2450 SATELLITE BLVD		DULUTH	GA	30096-5801
CERAM ENVIRONMENTAL INC	7304 W 130TH ST STE 140		OVERLAND PARK	KS	66213-2644
CHALLENGER CONSTRUCTION CORPORATION	PO BOX 216		GIRARD	KS	66743-0216
CHAPMAN CANOPY, INC.	PO BOX 3527		HUEYTOWN	AL	35023-0527
CHARLES C BRANDT & COMPANY INC	1505 N SHERMAN DR		INDIANAPOLIS	IN	46201-1517
CHARLES F EVANS CO INC	PO BOX 228		ELMIRA	NY	14902-0228
CHERNE CONTRACTING CORPORATION	3555 FARNAM ST		OMAHA	NE	68131-3311
CHEROKEE ENTERPRISES INC	14474 COMMERCE WAY		MIAMI LAKES	FL	33016-1508
CILLESSEN & SONS INC	PO BOX 9		KECHI	KS	67067-0009
CIRCLE C PAVING AND CONSTRUCTION LLC	PO BOX 361		GODDARD	KS	67052-0361

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CJ DRILLING INC	19N041 GALLIGAN RD		DUNDEE	IL	60118-9536
CL CONSTRUCTION, LLC	1927 COUNTY ROAD I		WAHOO	NE	68066-4074
CLASSIC INDUSTRIAL SERVICES INC	456 HIGHLANDIA DR		BATON ROUGE	LA	70810-5906
CLASSIC PROTECTIVE COATINGS INC	N 7670 STATE HWY 25		MENOMONIE	WI	54751
CLOVER TOOL COMPANY INC	PO BOX 820809		HOUSTON	TX	77282-0809
CLYDE BERGEMANN POWER GROUP AMERICAS	4015 PRESIDENTIAL PKWY		ATLANTA	GA	30340-3707
CMC ELECTRIC INC	PO BOX 37		COLLINSVILLE	IL	62234-0037
COACH HOUSE INC	PO BOX 320		ARTHUR	IL	61911
COASTAL ENVIRONMENTAL GROUP INC	7 POLICE PLZ		POTOSI	MO	63664-1877
COLCON INDUSTRIES CORPORATION	PO BOX 647		SULLIVAN	IL	61951-0647
COLUMBIA CONSTRUCTION INC	PO BOX 445		SPRING HILL	KS	66083-0445
COMBUSTION SERVICES INC	PO BOX 112		ALTAMONT	KS	67330-0112
COMMERCE CONSTRUCTION INC	695 N 40TH ST		SPRINGDALE	AR	72762-0602
COMMERCIAL CONSTRUCTION MANAGEMENT INC	222 E DUNKLIN ST STE 102		JEFFERSON CITY	MO	65101-3168
COMMONWEALTH ELECTRIC COMPANY OF THE MIDWEST	PO BOX 80638		LINCOLN	NE	68501-0638
COMMUNICATION ADVISERS INC	1330 FRONTIER LN		MANHATTAN	KS	66503-2537

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COMMUNICATION DATA LINK LLC	1305 SW 37TH ST		GRIMES	IA	50111-5064
CONCO SERVICES CORPORATION	135 SYLVAN ST		VERONA	PA	15147-1032
CONCORD TANK CORPORATION	PO BOX 5207		CONCORD	NC	28027-1503
CONCRETE EXPRESSIONS LLC	291 E GLENN MILLER DR		CLARINDA	IA	51632-2736
CONCRETE SYSTEMS COMPANY LLC	121 EDWARDS DR		JACKSON	TN	38301-7716
CONLEY SITEWORK & UTILITIES INC	PO BOX 715		EUDORA	KS	66025-0715
CONNECTED TECHNOLOGIES LLC	PO BOX 1983		ATHENS	GA	30603-1983
CONSTRUCTION DESIGNWORKS LLC	6657 WOODLAND DR		SHAWNEE	KS	66218-9745
CONSTRUCTION ENTERPRISES INC	2179 EDWARD CURD LN STE 100		FRANKLIN	TN	37067-5789
CONTEGRA SERVICES LLC	22 GTWAY COMM CTR W 110		EDWARDSVILLE	IL	62025
CONTINENTAL CONSTRUCTION COMPANY OF TENNESSEE INC	5646 SHELBY OAKS DR		MEMPHIS	TN	38134-7337
CONTINENTAL POOLS INC	805 E WARREN ST		GARDNER	KS	66030-1619
CONTRACTOR SOLUTION GROUP LLC	670 WHITE RD STE A		SPRINGDALE	AR	72762-3027
CONTROLS ENGINEERING AND SERVICES LLC	210 BARBERRY PL		LOVELAND	CO	80537-7124
CONWAY PHILLIPS HOLDING LLC	13A TALBOT AVE		BRADDOCK	PA	15104-1113
COOPER RAIL SERVICE INC	PO BOX 199		HUNTINGBURG	IN	47542-0199

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COOPERS STEEL FABRICATORS	PO BOX 149		SHELBYVILLE	TN	37162-0149
CORNERSTONE FCE SERVICES LLC	8811 TEEL PKWY UNIT 6074		FRISCO	TX	75035-4258
CORNHUSKER INSULATION LLC	2201 RIVER ROAD DR		WATERLOO	NE	68069-3407
CORRECTIVE ASPHALT MATERIALS LLC	PO BOX 87129		SOUTH ROXANA	IL	62087-7129
CORVAL CONSTRUCTORS INC	1633 EUSTIS ST		SAINT PAUL	MN	55108-1219
COTTON COMMERCIAL USA INC	5443 KATY HOCKLEY CUT OFF RD		KATY	TX	77493-7008
COULTER GLASS INC	13711 E 66TH ST N		OWASSO	OK	74055-7141
COUNTRY CARPET INC	14969 WATERMAN CROSSING		MAPLE HILL	KS	66507
COUNTRY CERAMIC LLC	14969 WATERMAN CROSSING RD		MAPLE HILL	KS	66507-8862
COUNTY CONTRACTORS INC	PO BOX 3522		QUINCY	IL	62305-3522
COWIN & CO INC MINING ENGINEERS AND CONTRACTORS	PO BOX 19009		BIRMINGHAM	AL	35219-9009
CRAIGS RESTORATION & REPAIR LLC	PO BOX 605		DURANT	IA	52747-0605
CRAMER AND ASSOCIATES INC	3100 SW BROOKSIDE DR		GRIMES	IA	50111-4977
CROOKHAM CONSTRUCTION LLC	PO BOX 339		TONGANOXIE	KS	66086-0339
CROWN CORR INC	7100 W 21ST AVE		GARY	IN	46406-2499
CTS CONSTRUCTION INC	7275 EDINGTON DR		CINCINNATI	OH	45249-1064

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CUNNINGHAM	847 FOX RUN LN		OSKALOOSA	IA	52577-4162
CUSTOM POOL LLC	32 HOWARD DR		BELLEVILLE	IL	62223-4016
CUSTOM TREE CARE INC	3722 SW SPRINGCREEK LN		TOPEKA	KS	66610-1221
CWPMO INC	1682 LANGLEY AVE		IRVINE	CA	92614-5620
D & D INDUSTRIAL CONTRACTING INC	101 MULLEN DR		WALTON	KY	41094-9607
D & L EXCAVATING INC	1958 HIGHWAY 104		LIBERTY	IL	62347-2141
D AN T ROOFING LLC	32470 LONE STAR RD LOT A27		PAOLA	KS	66071
D MCGINNIS INDUSTRIES INC	7 INDUSTRIAL PARK		CAHOKIA	IL	62206-1077
DADE CONSTRUCTION LLC	PO BOX 4090		KANSAS CITY	KS	66104-0090
DANIEL UTILITY CONSTRUCTION INC	9715 COLONEL GLENN RD		LITTLE ROCK	AR	72204-8129
DAVID SCHMITT	390 SELBY ST		SAN FRANCISCO	CA	94124-1114
DAVIS CONSTRUCTION	2143 NE HIGHWAY 7		COLUMBUS	KS	66725-2093
DAWKINS ON-SITE, LLC	PO BOX 1096		HARTSVILLE	SC	29551-1096
DAYTON LEASE AND PIPELINE SERVICES INC.	PO BOX 72		DAYTON	TX	77535-0002
DB CONSTRUCTION INC	2608 AVENUE I		COUNCIL BLFS	IA	51501-0897
DB HEALTHCARE INC	5 GERMANO WAY		ANDOVER	MA	01810-4540
DBS GROUP LLC	2700 NATIONAL DR STE 101		ONALASKA	WI	54650-6709
DCG PETERSON BROTHERS COMPANY	PO BOX 349		SIOUX RAPIDS	IA	50585-0349
DEAN SNYDER CONSTRUCTION CO	PO BOX 181		CLEAR LAKE	IA	50428-0181

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DECKER CONSTRUCTION INC	PO BOX 254		COFFEYVILLE	KS	67337-0254
DECKER ELECTRIC INC	4500 W HARRY ST		WICHITA	KS	67209-2736
DEGRAFF CONSTRUCTION LLC	3584 AUSTIN DR		JOPLIN	MO	64804
DEJAGER CONSTRUCTION INC	75 60TH ST SW		WYOMING	MI	49548-5771
DELTA CONCRETE AND INDUSTRIAL CONTRACTING INC	51825 GRATIOT AVE		CHESTERFIELD	MI	48051-2014
DENISON DRYWALL CONTRACTING INC	PO BOX 453		DENISON	IA	51442-0453
DETROIT PIPING GROUP MECHANICAL CONTRACTORS INC	38291 SCHOOLCRAFT RD STE 105		LIVONIA	MI	48150-1150
DF CHASE INC	3001 ARMORY DR STE 200		NASHVILLE	TN	37204-3711
DF OSBORNE CONSTRUCTION INC	3310 SW HARRISON ST STE 3		TOPEKA	KS	66611-2252
DIAMOND CONSTRUCTION COMPANY	2000 N 18TH ST		QUINCY	IL	62301-1435
DIECKER-TERRY MASONRY INC	11327 EIFF RD		MARISSA	IL	62257-1409
DIG AMERICA UTILITY CONTRACTING INC	25135 22ND AVE		SAINT CLOUD	MN	56301-9189
DIMENSION CONSTRUCTION INC	3776 NEW GETWELL RD		MEMPHIS	TN	38118-6014
DISCOVER PLUMBING ST LOUIS LLC	2436 AUBURN RD		SHELBY TWP	MI	48317-3900
DIVERSIFIED TRACK WORKS LLC	17671 US HIGHWAY 6		GENESEO	IL	61254-8620

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Contractor Name	Street Address	Street Address 2	City	State	Zip Code
DL SMITH ELECTRICAL CONSTRUCTION INC	1405 SW 41ST ST		TOPEKA	KS	66609-1295
DOME CORPORATION OF NORTH AMERICA	5450 EAST RD		SAGINAW	MI	48601-9748
DON JULIAN BUILDERS INC	15521 W 110TH ST		LENEXA	KS	66219-1317
DONCO ELECTRICAL CONSTRUCTION LLC	PO BOX 158		EDWARDSVILLE	IL	62025-0158
DORMARK CONSTRUCTION CO	PO BOX 530		GRIMES	IA	50111-0530
DOSTER CONSTRUCTION COMPANY INC	2100 INTERNATIONAL PARK DR		BIRMINGHAM	AL	35243-4209
DOTSON ELECTRIC COMPANY INC	551 CAL BATSEL RD		BOWLING GREEN	KY	42104-8520
DRC EMERGENCY SERVICES LLC	110 VETERANS MEMORIAL BLVD		METAIRIE	LA	70005-3027
DS ELECTRIC LLC	5336 KNOX ST		MERRIAM	KS	66203-2066
DTLS INCORPORATED	PO BOX 1615		BERNALILLO	NM	87004-1615
DUANE HOUKOM INC	PO BOX 1206		FRIENDSWOOD	TX	77549-1206
DUFFY CONSTRUCTION COMPANY INC	7211 W 98TH TER STE 110		OVERLAND PARK	KS	66212-2257
DUINICK INC	PO BOX 208		PRINSBURG	MN	56281-0208
DUN TRANSPORTATION & STRINGING INC	304 REYNOLDS LN		SHERMAN	TX	75092-6839
DUNK FIRE & SECURITY INC	3446 WAGON WHEEL RD		SPRINGDALE	AR	72762-0115
E80 PLUS CONSTRUCTORS LLC	7120 PATTON RD		DEFOREST	WI	53532-1836
EBERHART SIGN & LIGHTING CO	104 1ST AVE		EDWARDSVILLE	IL	62025-2574

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EBERT CONSTRUCTION CO INC	PO BOX 198		WAMEGO	KS	66547-0198
EBM CONSTRUCTION INC	1014 SHERWOOD RD		NORFOLK	NE	68701-9060
ECKINGER CONSTRUCTION COMPANY	2340 SHEPLER CHURCH AVE SW		CANTON	OH	44706-3093
EDNA LUMBER CO INC	PO BOX 820		EDNA	TX	77957-0820
EDWINS GREENHOUSE CONSTRUCTION INC	6586 POWDER VALLEY RD		ZIONSVILLE	PA	18092-2225
EJM PIPE SERVICE INC	14461 LAKE DR NE		COLUMBUS	MN	55025-8600
ELECTRICO INC	7706 WAGNER RD		MILLSTADT	IL	62260-2910
ELECTRICOMM INC	PO BOX 8324		TOPEKA	KS	66608-0324
ELEVATOR SAFETY INSPECTION SERVICES INC	PO BOX 6866		SHERWOOD	AR	72124-6866
ELLINGSON DRAINAGE INC	PO BOX 68		WEST CONCORD	MN	55985-0068
ELLIOTT ELECTRICAL INC	117 S RICHARDS ST		BENTON	AR	72015-4239
ELLIOTT ROOFING LLC	3900 N HARVARD AVE		OKLAHOMA CITY	OK	73122-2511
ELLSWORTH ELECTRIC INC	4425 N HIGHWAY 81		DUNCAN	OK	73533-8950
EMBREE CONSTRUCTION GROUP INC OF TEXAS	4747 WILLIAMS DR		GEORGETOWN	TX	78633-3799
EMCO CHEMICAL DISTRIBUTORS INC	8601 95TH ST		PLEASANT PR	WI	53158-2205
EMERALD TRANSFORMER PPM LLC	4419 ST HWY 83 N		DEFUNIAK SPRINGS	FL	32433-3958
EMJ CORPORATION	2034 HAMILTON PLACE BLVD STE 400		CHATTANOOGA	TN	37421-6102
EMPIRE CONSTRUCTION GROUP LLC	9128 W 91ST TER		OVERLAND PARK	KS	66212-3901

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ENERGY ERECTORS INC	31588 PROGRESS RD		LEESBURG	FL	34748-8781
ENGINEERED FLUID INC	PO BOX 723		CENTRALIA	IL	62801-9111
ENGINEERED STRUCTURES INC	3330 E LOUISE DR STE 300		MERIDIAN	ID	83642-5123
ENGLEWOOD CONSTRUCTION INC	80 MAIN ST		LEMONT	IL	60439-3622
ENHANCED SITE SOLUTIONS LLC	1701 GOLF RD STE 1-900		ROLLING MEADOWS	IL	60008-4246
ENVIROCON INC	PO BOX 16655		MISSOULA	MT	59808-6655
ENVIRONMENTAL FABRICS INC	85 PASCON CT		GASTON	SC	29053-8507
EPC SERVICES COMPANY	1241 S 31ST ST W		BILLINGS	MT	59102-7314
ERV SMITH SERVICES INC	1225 TRUAX BLVD		EAU CLAIRE	WI	54703-1468
ESA SOUTH INC	1681 SUCCESS DR		CANTONMENT	FL	32533-5103
ESSI LLC	1400 W SHADY GROVE RD		GRAND PRAIRIE	TX	75050-7117
EXCEL ENERGY GROUP INC	PO BOX 1281		RUSSELLVILLE	AR	72811-1281
F & M CONTRACTORS INC	PO BOX 149		CLAYTON	OH	45315-0149
F L CRANE & SONS INC	PO BOX 428		FULTON	MS	38843-0428
FABCOR INC	350 S OHIO ST		MINSTER	OH	45865-1272
FARABEE MECHANICAL INC	PO BOX 1748		HICKMAN	NE	68372-1748
FAUGHN ELECTRIC INC	5980 OLD MAYFIELD RD		PADUCAH	KY	42003-9296
FAYETTEVILLE PLUMBING & HEATING CO INC	PO BOX 8910		FAYETTEVILLE	AR	72703-0016
FC DADSON SIB LLC	N1043 CRAFTSMEN DR STE 2		GREENVILLE	WI	54942-8082

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FEDERAL ENGINEERS AND CONSTRUCTORS INC	3240 RICHARDSON RD		RICHLAND	WA	99354-5501
FEDERAL STEEL & ERECTION CO	PO BOX 238		EAST ALTON	IL	62024-0238
FHG INC	7015 TUTOR ST		MINT HILL	NC	28227-4421
FIRE & SECURITY SOLUTIONS GROUP INC	11240 STRANG LINE RD		LENEXA	KS	66215-4039
FIRELAKE CONSTRUCTION INC	14217 W 95TH ST		LENEXA	KS	66215-5208
FIRELINE SPRINKLER LLC	1329 W GRAND AVE STE 1A		PORT WASHINGTON	WI	53074-2010
FISH & ASSOCIATES INC	3148 DEMING WAY STE 160		MIDDLETON	WI	53562-1486
FISHER SMITH INC	1564 HILL TOP RD		COLUMBIA	IL	62236-4536
FLORIDA INSTITUTE OF TECHNOLOGY INC	150 W UNIVERSITY BLVD		MELBOURNE	FL	32901-6975
FORD AUDIO VIDEO SYSTEMS LLC	4800 W I 40 SERVICE RD		OKLAHOMA CITY	OK	73128-1208
FORJAK INDUSTRIAL INC	808 RHODAS AVE		COLUMBUS	OH	43205-2572
FORTESSA HOSTING	PO BOX 1734		LAGUNA BEACH	CA	92652-1734
FOSTER ROOFING INC	3357 WAGON WHEEL RD		SPRINGDALE	AR	72762-0106
FOUNDATION SERVICE CORP	PO BOX 120		HUDSON	IA	50643-0120
FOUNDATION SPECIALTIES INC	PO BOX 505		LOWELL	AR	72745-0505
FOUR STAR CONSTRUCTION INC	PO BOX 3037		SUPERIOR	WI	54880-0458
FRAZIER ROOFING & SHEET METAL CO INC	PO BOX 545		DYERSBURG	TN	38025-0545

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FREEDOM CONCRETE LLC	PO BOX 731		DE SOTO	KS	66018-0731
FRONTIER MECHANICAL LC	PO BOX 71487		SALT LAKE CTY	UT	84171-0487
FRONTZ DRILING INC	2031 MILLERSBURG RD		WOOSTER	OH	44691-9460
FSG FACILITY SOLUTIONS GROUP INC	4401 W GATE BLVD STE 310		AUSTIN	TX	78745-1494
FULCRUM EXPRESS INC	1945 THE EXCHANGE SE STE 400		ATLANTA	GA	30339-2090
FULSOM BROTHERS INC	PO BOX 522		CEDAR VALE	KS	67024-0522
G B CONSTRUCTION LLC	PO BOX 1305		LOUISBURG	KS	66053-1305
G.A. RICH & SONS INC	PO BOX 50		DEER CREEK	IL	61733-0050
GARRISON PLUMBING INC	1375 N WINCHESTER ST		OLATHE	KS	66061-5880
GARTNER REFRIGERATION & MANUFACTURING INC	13205 16TH AVE N		MINNEAPOLIS	MN	55441-4566
GATOR SIGN COMPANY INC	1027 KAREY ANDREWS RD		MCCOMB	MS	39648-9446
GBA SYSTEMS INTEGRATORS LLC	9801 RENNER BLVD		LENEXA	KS	66219-9718
GEMCO CONSTRUCTORS LLC	6525 GUION RD		INDIANAPOLIS	IN	46268-4808
GENERAL EXCAVATING COMPANY	6701 CORNHUSKER HWY		LINCOLN	NE	68507-3113
GENESEE FENCE & SUPPLY CO	PO BOX 458		RICHMOND	MI	48062-0458
GERARD TANK & STEEL INC	PO BOX 513		CONCORDIA	KS	66901-0513
GERENA CONSTRUCTION LLC	9517 E 85TH ST N		VALLEY CENTER	KS	67147
GHPS INC	PO BOX 192449		DALLAS	TX	75219-8520

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Contractor Name	Street Address	Street Address 2	City	State	Zip Code
GIBALTAR CONSTRUCTION COMPANY INC	42 HUDSON ST STE A207		ANNAPOLIS	MD	21401-8537
GIFFIN INC	1900 BROWN RD		AUBURN HILLS	MI	48326-1701
GLASS DESIGN INC	PO BOX 568		SAPULPA	OK	74067-0568
GLEESON ASPHALT INC	2800 W MAIN ST		BELLEVILLE	IL	62226-6612
GLOBAL CONSTRUCTION GROUP INC	PO BOX 1785		LONGVIEW	WA	98632-8105
GLOBAL EMPIRE LLC	115 OVERLOOK RD		POMONA	NY	10970-2118
GLOBAL ENERGY SOLUTIONS	707 SABLE OAKS DR STE 150		S PORTLAND	ME	04106-6954
GLOBAL TECHNICAL SOLUTIONS LLC	2900A LAUSAT ST		METairie	LA	70001-5952
GLUE LAM ERECTORS INC	PO BOX 10		TRAFALGAR	IN	46181-0010
GOOLSBY INC	3002 W MAIN ST		BLyTHEVILLE	AR	72315-8600
GORDON ENERGY AND DRAINAGE COMPANY	15735 S MAHAFFIE ST		OLATHE	KS	66062-4038
GRAND CONSTRUCTION COMPANY LLC	1699 VILLAGE WEST PKWY		KANSAS CITY	KS	66111-1878
GRAND RAPIDS POURED WALLS	8559 PIEDMONT IND DR SW		BYRON CENTER	MI	49315-9356
GRANITE TRANSFORMATIONS	14125 MARSHALL DR		LENEXA	KS	66215-1300
GRE CONSTRUCTION	628 PALESTINE RD		CHESTER	IL	62233-1060
GREAT LAKES CONCRETE PRODUCTS LLC	4555 134TH AVE		HAMILTON	MI	49419-8579
GREAT PLAINS STRUCTURES LLC	3315 LABORE RD		VADNAIS HTS	MN	55110-5149

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GRIBBINS INSULATION COMPANY INC	1400 E COLUMBIA ST		EVANSVILLE	IN	47711-5222
GRIFFIN CONTRACT DEWATERING LLC	5306 CLINTON DR		HOUSTON	TX	77020-7912
GRIFFITH STEEL ERECTION	1355 S ANNA ST		WICHITA	KS	67209-2601
GROOME INDUSTRIAL SERVICE GROUP INC	155 FRANKLIN TPKE		WALDWICK	NJ	07463-1816
GUN KO TRAFFIC CONTROL INC	901 W IRONWOOD ST		OLATHE	KS	66061-5384
GUNTERMAN CONSTRUCTION INC	205 E QUINCY ST	P O BOX 423	PLEASANT HILL	IL	62366-2404
GUS CONST CO INC	PO BOX 77		CASEY	IA	50048-0077
GUSTAFSON & GOUDGE INC	PO BOX 28		CLEARBROOK	MN	56634-0028
GUY F ATKINSON CONSTRUCTION LLC	7500 OLD GEORGETOWN RD STE 8		BETHESDA	MD	20814-6805
GUY ROOFING INC	201 JONES RD		SPARTANBURG	SC	29307-5424
GYPSON FLOORS OF AR/OK INC	PO BOX 1707		MULDROW	OK	74948-1707
H & H DRYWALL SPECIALTIES INC	3727 E 31ST ST		TULSA	OK	74135-1506
H & H SYSTEMS AND DESIGN, INC	135 W MARKET ST		NEW ALBANY	IN	47150-3561
H & M HEAVY EQUIPMENT REPAIR INC	6121 MARINE RD		ALHAMBRA	IL	62001-2021
H & M INDUSTRIAL SERVICES INC	PO BOX 200		JACKSON	TN	38302-0200
H AND M CONSTRUCTION CO INC	PO BOX 200		JACKSON	TN	38302-0200

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HABASIT AMERICA INC	2670 LEISCZS BRIDGE RD UNIT 200		LEESPORT	PA	19533-9433
HABCO INC	248 E BERG RD		SALINA	KS	67401-8907
HAIER PLUMBING & HEATING INC	301 N ELKTON ST		OKAWVILLE	IL	62271-1896
HALL CONTRACTING OF KENTUCKY INC	PO BOX 37270		LOUISVILLE	KY	40233-7270
HAMON CUSTODIS INC	PO BOX 1500		SOMERVILLE	NJ	08876-1251
HANNA DESIGN GROUP INC	650 E ALGONQUIN RD STE 405		SCHAUMBURG	IL	60173-3853
HANSEN RICE INC	1717 E CHISHOLM DR		NAMPA	ID	83687-6846
HARBOUR CONSTRUCTION INC	2717 S 88TH ST		KANSAS CITY	KS	66111-1757
HARCO SERVICES LLC	PO BOX 2347		KENNESAW	GA	30156-9105
HAREN & LAUGHLIN RESTORATION COMPANY INC	8035 NIEMAN RD		LENEXA	KS	66214-1544
HAROLD COFFEY CONSTRUCTION CO INC	2317 S 7TH ST		HICKMAN	KY	42050-1835
HARVEY NASH INC	1680 ROUTE 23 STE 300		WAYNE	NJ	07470-7520
HASTCO INC	2801 NW BUTTON RD		TOPEKA	KS	66618-1457
HAWKEYE INSULATION SPECIALISTS INC	755 64TH AVENUE CT SW STE A		CEDAR RAPIDS	IA	52404-7001
HEADWATERS CONSTRUCTION COMPANY	639 W 9500 S STE 1		VICTOR	ID	83455-5408
HEAFNER CONTRACTING INC	27457 HEAFNER DR		GODFREY	IL	62035-3635
HEALY CONSTRUCTION SERVICES INC	14000 KEELER AVE		CRESTWOOD	IL	60418-2352

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Contractor Name	Street Address	Street Address 2	City	State	Zip Code
HEARTLAND ACCESS SOLUTIONS LLC	8401 MELROSE DR		LENEXA	KS	66214-1647
HEARTLAND RETAIL CONSTRUCTION INC	4956 MEMCO LN STE A		RACINE	WI	53404-1160
HEIDELBERG ENGINEERING INC	10 FORGE PKWY STE 1		FRANKLIN	MA	02038-3137
HEINEN CUSTOM OPERATIONS INC	PO BOX 182		VALLEY FALLS	KS	66088-0182
HEINTZ POOL & SPA COMPANY	453 MARKETPLACE DR		FREEBURG	IL	62243-4076
HELLAS CONSTRUCTION INC	12710 RESEARCH BLVD STE 240		AUSTIN	TX	78759-4319
HENSON CONSTRUCTION LLC	11501 PLANTSIDE DR STE 9		LOUISVILLE	KY	40299-6334
HICKEY CONTRACTING COMPANY	PO BOX 68		KEOKUK	IA	52632-0068
HIGH CONCRETE GROUP LLC	PO BOX 10008		LANCASTER	PA	17605-0008
HIGHLAND STEEL ERECTORS INC	PO BOX 590		HELENWOOD	TN	37755-0590
HILL DB LLC	234 MAIN ST		KELLER	TX	76262
HILLARD ELECTRIC INC	4099 CEDAR COMMERCIAL DR NE		CEDAR SPRINGS	MI	49319-8296
HODESS CONSTRUCTION CORPORATION	100 JOHN L DIETSCH SQ		N ATTLEBORO	MA	02763-1028
HOFFMANN INC	6001 49TH ST S		MUSCATINE	IA	52761-1153
HOHL INDUSTRIAL SERVICES INC	770 RIVERVIEW BLVD STE 1		TONAWANDA	NY	14150-7880
HOLDER CONSTRUCTION	3300 RIVERWOOD PKWY SE STE 1200		ATLANTA	GA	30339-3967

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HOLLAND CONSTRUCTION SERVICES, INC.	4495 N ILLINOIS ST STE E		SWANSEA	IL	62226-1005
HOME CENTER CONSTRUCTION INC	420 W ATKINSON RD		PITTSBURG	KS	66762-8634
HOPCO CONSTRUCTION	PO BOX 9008		OMAHA	NE	68109-0008
HORIZON GENERAL CONTRACTORS INC	7315 W ELIZABETH LN		FT WORTH	TX	76116-6444
HORIZONTAL BORING & TUNNELING CO	PO BOX 429		EXETER	NE	68351-0429
HOWARD IMMEL INC	1820 RADISSON ST		GREEN BAY	WI	54302-2057
HPI LLC	15503 W HARDY RD		HOUSTON	TX	77060-3603
HUEGERICH CONSTRUCTION INC	PO BOX 891		GRETNA	NE	68028-0891
HUSTON CONTRACTING INC	PO BOX 74		OLATHE	KS	66051-0074
HUTTON CONTRACTING CO INC	1600 CLIFTY HWY		HINDSVILLE	AR	72738-9167
HYDRA-LUBE	PO BOX 16565		LAKE CHARLES	LA	70616-6565
HYDRO TECHNOLOGIES INC	6200 E HIGHWAY 62 UNIT 100		JEFFERSONVILLE	IN	47130-8769
HYDROCHEM LLC	900 GEORGIA AVE		DEER PARK	TX	77536-2518
ICON INDUSTRIAL SERVICES LLC	5104 J ST SW		CEDAR RAPIDS	IA	52404-4919
IDEAL BUSINESS SOLUTIONS LLC	31 BOLAND CT		GREENVILLE	SC	29615-5730
ILLINI DRILLED FOUNDATIONS INC	PO BOX 1351		DANVILLE	IL	61834-1351
IMPACT INSTALLATIONS INC	10091 STREETER RD STE 7		AUBURN	CA	95602-8512
IMPERIAL CRANE SERVICES INC	7500 IMPERIAL DR		BRIDGEVIEW	IL	60455-2395

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IMPERIAL ROOF SYSTEMS CO	PO BOX 522		WEST UNION	IA	52175-0522
INDUSTRIAL INSULATION SERVICES INC	2200 W 6TH AVE		EL DORADO	KS	67042-3166
INDUSTRIAL MAINTENANCE CONTRACTORS INC	2301 GARDEN CITY HWY		MIDLAND	TX	79701-1549
INDUSTRIAL MAINTENANCE OF TOPEKA INC	4501 NW US HIGHWAY 24		TOPEKA	KS	66618-3809
INDUSTRIAL PLANT SERVICES NATIONAL LLC	51410 MILANO DR STE 110		MACOMB	MI	48042-4015
INDUSTRIAL ROOFING & CONSTRUCTION LLC	1128 HIGHWAY 2		STERLINGTON	LA	71280-3066
INDUSTRIAL STEEL ERECTORS INC	2728 N CLARK ST		DAVENPORT	IA	52804-1300
INDUSTRY SERVICES CO INC	6265 RANGELINE RD		THEODORE	AL	36582-5245
INFRASTRUCTURE ENGINEERS INC	12596 W BAYAUD AVE STE 300		LAKEWOOD	CO	80228-2031
INGRAM CONSTRUCTION COMPANY INC OF MADISON MISSISS	PO BOX 1609		MADISON	MS	39130-1609
INK CONSTRUCTION LLC	8335 E KELLOGG DR		WICHITA	KS	67207-1839
INNOVATIVE COMBUSTION TECHNOLOGIES INC	10 COMMERCE DR		PELHAM	AL	35124-1847
INNOVATIVE CONSTRUCTION SOLUTIONS INC	21675 GATEWAY RD		BROOKFIELD	WI	53045-5137
INNOVATIVE SOLUTIONS IN SIGNALING CONSULTANTS	108 S MADISON AVE STE 200		LOUISVILLE	KY	40243-1473
INSULATED PANEL COMPANY	421 N PAULINA ST		CHICAGO	IL	60622-6684
INSULATION TECHNOLOGIES INC	2007 BUTTON LN		LA GRANGE	KY	40031-8726

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INTEGRATED ENVIRONMENTAL SERVICES INC	PO BOX 490815		BLAINE	MN	55449-0815
INTEGRATED POWER CO	PO BOX 1743		NORTH PLATTE	NE	69103-1743
INTEGRATED SERVICE COMPANY	1900 N 161ST EAST AVE		TULSA	OK	74116-4829
INTERCON CONSTRUCTION INC	5512 STATE ROAD 19 AND 113		WAUNAKEE	WI	53597-9530
INTERNATIONAL CONTRACTORS INC	977 S IL ROUTE 83		ELMHURST	IL	60126-4966
INTERNATIONAL INDUSTRIAL CONTRACTING CORPORATION	35900 MOUND RD		STERLING HTS	MI	48310-4793
IOWA TRENCHLESS LC	PO BOX 846		PANORA	IA	50216-0846
IVS HYDRO INC	PO BOX 245		WAVERLY	WV	26184-0245
J & D CONSTRUCTION INC	4326 HIGHWAY 212		MONTEVIDEO	MN	56265-4536
J F BRENNAN COMPANY INC	PO BOX 2557		LA CROSSE	WI	54602-2557
J HAWK PLUMBING INC	3615 W MAPLE ST		WICHITA	KS	67213-2453
J WILKINSON INC	2964 PETTICOAT JUNCTION LN		GLEN CARBON	IL	62034-3265
J.E.D. INSTALLATION LLC	2722 N 155TH ST		BASEHOR	KS	66007-9253
JACK R GAGE REFRIGERATION INC	700 W 1700 S BLDG 29104		LOGAN	UT	84321-6541
JACKOVIC CONSTRUCTION COMPANY LLC	300 MOUNT LEBANON BLVD STE 211A		PITTSBURGH	PA	15234-1534
JACKSON DEAN CONSTRUCTION INC	3414 S 116TH ST		TUKWILA	WA	98168-1983
JACOBS LADDER INC	2325 COBDEN SCHOOL RD		COBDEN	IL	62920-3489

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JAKES ELECTRIC LLC	207 ALLEN ST		CLINTON	WI	53525-9498
JAMES HUNT CONSTRUCTION CO INC	1865 SUMMIT RD		CINCINNATI	OH	45237-2803
JAMES MCHUGH CONSTRUCTION CO	1737 S MICHIGAN AVE		CHICAGO	IL	60616-1211
JAMES N GRAY CONSTRUCTION CO INC	PO BOX 8330		LEXINGTON	KY	40533-8330
JANSEN ELECTRIC COMPANY	4421 N 60TH ST		QUINCY	IL	62305-0640
JARRETT INDUSTRIES INC	PO BOX 87189		SOUTH ROXANA	IL	62087-7189
JASON TANKING CONSTRUCTION LLC	PO BOX 3969		LAWRENCE	KS	66046-0969
JAY MCCONNELL CONSTRUCTION INC	5721 GEORGIA AVE		KANSAS CITY	KS	66104-2937
JAY TON CONSTRUCTION CO INC	PO BOX 142		BURLISON	TN	38015-0142
JAYEFF CONSTRUCTION CORPORATION	2310 HIGHWAY 34 STE 1A		MANASQUAN	NJ	08736-1400
JDH CONTRACTING INC	8109 NETWORK DR		PLAINFIELD	IN	46168-9024
JE SYSTEMS INC	PO BOX 6246		FORT SMITH	AR	72906-6246
JEN MECHANICAL INC	803 HOPP HOLLOW DR		ALTON	IL	62002-4204
JESCO INC	2020 MCCULLOUGH BLVD		TUPELO	MS	38801-7108
JETTON GENERAL CONTRACTING INC	1211 CARROLL RD		PARAGOULD	AR	72450-6088
JF EDWARDS CONSTRUCTION COMPANY	220 S CHICAGO ST		GENESEO	IL	61254-1456
JIM BROWN CONSTRUCTION COMPANY INC	PO BOX 2218		MOUNTAIN HOME	AR	72654-2218

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Contractor Name	Street Address	Street Address 2	City	State	Zip Code
JOE R JONES CONSTRUCTION INC	PO BOX 873		WEATHERFORD	TX	76086-0873
JOHN A PAPALAS & CO INC	1187 EMPIRE AVE		LINCOLN PARK	MI	48146-2099
JOHN E GREEN COMPANY	220 VICTOR ST		HIGHLAND PARK	MI	48203-3116
JOHNSONS BUILDERS	1455 HODGES FERRY RD		DOYLE	TN	38559-3001
JONES HYDROBLAST INC	PO BOX 309		ROYALTON	IL	62983-0309
JRCT INCORPORATED	2098 TOM AUSTIN HWY		GREENBRIER	TN	37073-5192
JVT ADVISORS	35 NEW ENGLAND BUS CNTR		ANDOVER	MA	01810
K & M CONCRETE CONSTRUCTION INC	PO BOX 236		EDGERTON	MN	56128-0236
KADILEX CONSTRUCTION INC	PO BOX 348		WOOD RIVER	IL	62095-0348
KAISER ELECTRICAL CONTRACTORS INC	340 ERIE AVE		MORTON	IL	61550-9600
KALMAN FLOOR COMPANY	15710 W COLFAX AVE STE 202		GOLDEN	CO	80401-7405
KAMADULSKI EXCAVATING & GRADING CO INC	4336 HIGHWAY 162		GRANITE CITY	IL	62040-6409
KANSAS TURF LLC	601 E WYANDOTTE ST		MERIDEN	KS	66512-9169
KARR TUCKPOINTING LLC	PO BOX 417		VINTON	IA	52349-0417
KASBOHM CUSTOM DRILLING INC	11404 OAKTON RD		SAVANNA	IL	61074-8636
KASPARIE CONSTRUCTION COMPANY	1500 MAAS RD		QUINCY	IL	62305-0436
KBC INC	11404 OAKTON RD		SAVANNA	IL	61074-8636
KBS AGRI SYSTEMS LLC	255 COUNTY ROAD R		NAPOLEON	OH	43545-5748

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KBS CONSTRUCTORS INC	1701 SW 41ST ST		TOPEKA	KS	66609-1252
KC DOORS INC	N57W13556 REICHERT AVE		MENOMONEE FLS	WI	53051-6106
KC HAWKS CONSTRUCTION LLC	2915 S 9TH TER		KANSAS CITY	KS	66103-2549
KEA CONSTRUCTORS LLC	PO BOX M		MILFORD	NE	68405-0623
KEELEY & SONS INC	6303 COLLINSVILLE RD		E SAINT LOUIS	IL	62201-2523
KEEN COMPANY INC	PO BOX 2143		INDIANAPOLIS	IN	46206-2143
KEMBER FLOORING INC	5401 S GRAHAM RD		SAINT CHARLES	MI	48655-8584
KEMNER E.I.F.S., INC	PO BOX 41		QUINCY	IL	62306-0041
KENDALL CONSTRUCTION INC	2551 NW BUTTON RD		TOPEKA	KS	66618-1411
KENDREK ELECTRIC INC	PO BOX 9411		WICHITA	KS	67277-0411
KENEWICK LLC	2107 W HARRY ST		WICHITA	KS	67213-3253
KENT COMPANIES TEXAS LLC	830 VALLEY RIDGE BLVD		LEWISVILLE	TX	75057-3319
KEOKUK CONTRACTORS INC	853 JOHNSON STREET RD		KEOKUK	IA	52632-2213
KING MECHANICAL CONTRACTORS INC	PO BOX 16608		CHATTANOOGA	TN	37416-0608
KING OF TEXAS ROOFING COMPANY LP	307 GILBERT CIR		GRAND PRAIRIE	TX	75050-6579
KINLEY CONSTRUCTION GROUP LP	7301 COMMERCIAL BLVD E		ARLINGTON	TX	76001-7149
KLAVER CONSTRUCTION COMPANY INC	PO BOX 9163		WICHITA	KS	67277-0163
KNUTSON BROTHERS INC	PO BOX 353		REDWOOD FALLS	MN	56283-0353
KOOPS INC	987 PRODUCTIONS CT		HOLLAND	MI	49423-9219

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KORTE & LUITJOHAN CONTRACTORS INC	12052 HIGHLAND RD		HIGHLAND	IL	62249-1342
KOSS CONSTRUCTION COMPANY	5830 SW DRURY LN		TOPEKA	KS	66604-2262
KRUSE CONTRACTING INC	4374 G RD		WATERLOO	IL	62298-3806
KRUSE CORPORATION	8971 GREEN VALLEY DR UNIT 1		MANHATTAN	KS	66502-9008
KUHLMAN REFRIGERATION INC	N56W16865 RIDGEWOOD DR # 100		MENOMONEE FLS	WI	53051-5656
L.C.I. CONCRETE, INC.	4055 W JACKSON ST		MACOMB	IL	61455-7723
LABCON INC	PO BOX 535324		GRAND PRAIRIE	TX	75053-5324
LAKEVIEW CONSTRUCTION OF WISCONSIN INC	10505 CORPORATE DR STE 200		PLEASANT PR	WI	53158-1605
LAND ART LANDSCAPING INC	12429 HOWE DR		LEAWOOD	KS	66209-1451
LANEY DIRECTIONAL DRILLING CO	831 CROSSBRIDGE DR		SPRING	TX	77373-3501
LANGHAUSER SHEET METAL CO	120 MATTER DR		HIGHLAND	IL	62249-1271
LANHAM INSULATION INC	40 KINGBROOK PKWY STE 4		SIMPSONVILLE	KY	40067
LARSON HARVESTING INC	447 SUNFLOWER RD		WATERVILLE	KS	66548-8904
LATSHAW DRILLING COMPANY, LLC	PO BOX 691017		TULSA	OK	74169-1017
LAYTON CONSTRUCTION COMPANY LLC	9090 S SANDY PKWY		SANDY	UT	84070-6409
LEANTRAK INC	1645 INDIAN WOOD CIR STE 101		MAUMEE	OH	43537-4419
LEICK CONSTRUCTION INC	22027 221ST ST		GLENWOOD	IA	51534-5389

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LEISURE CONSTRUCTION & RENOVATION LLC	PO BOX 11546		PRAIRIE VLG	KS	66207-4246
LEJAS CORPORATION	6202 S MAPLE AVE		TEMPE	AZ	85283-2861
LEVELOPS INC	36 NE 52ND ST		OKLAHOMA CITY	OK	73105-1826
LEXICON INC	PO BOX 16390		LITTLE ROCK	AR	72231-6390
LIGHTNING PROTECTION SYSTEMS LLC	PO BOX 540445E		N SALT LAKE	UT	84054-0445
LILJA CORP	229 RICKENBACKER CIR		LIVERMORE	CA	94551-7616
LM WIND POWER SERVICE AMERICAS INC	1580 S 48TH ST		GRAND FORKS	ND	58201-3808
LOCKE EQUIPMENT SALES CO INC	PO BOX 243		SHAWNEE MSN	KS	66201-0243
LOELLKE PLUMBING INC	22974 E COUNTY RD		JERSEYVILLE	IL	62052-3174
LONE STAR RAILROAD CONTRACTORS INC	PO BOX 1150		ENNIS	TX	75120-1150
LONG ELECTRIC LLC	924 CONGRESS CIR		JONESBORO	AR	72401-2546
LONGHORN ORGANICS LLC	214 E US HIGHWAY 80		FORNEY	TX	75126-8665
LONGS DRILLING SERVICE INC	10554 HIGHWAY 392 W		HARRISON	AR	72601-7771
LOTEMP EQUIPMENT COMPANY	8707 N 29TH ST		OMAHA	NE	68112-1848
LOUK AG SERVICES LLC	506 E RUSSELL ST		JEFFERSON	IA	50129-4700
LOYD BUILDERS INC	PO BOX 266		OTTAWA	KS	66067-0266
LSX CONSTRUCTION LLC	34605 W 255TH ST		PAOLA	KS	66071-4213
LUCAS INC	12525 ANTIOCH RD STE 102		OVERLAND PARK	KS	66213-2001

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LUEDER CONSTRUCTION COMPANY	9999 J ST STE B		OMAHA	NE	68127-1125
LUND ROSS CONSTRUCTORS INC	4601 F ST		OMAHA	NE	68117-1403
LYNN ELECTRIC & COMMUNICATIONS, INC.	725 N 2ND ST STE K		LAWRENCE	KS	66044-1442
M & J ELECTRIC OF WICHITA LLC	1444 S SAINT CLAIR AVE BLDG D		WICHITA	KS	67213-2938
M & L ELECTRICAL INC	6060 SCOTTSVILLE RD		BOWLING GREEN	KY	42104-0388
M & W CONTRACTORS INC	PO BOX 2510		EAST PEORIA	IL	61611-0510
M CHEMICAL COMPANY INC	825 COLORADO BLVD STE 214		LOS ANGELES	CA	90041-1732
M.G. DYESS INC	7159 HIGHWAY 35		BASSFIELD	MS	39421-9678
M4 CONSTRUCTION LLC	6497 DEEP VALLEY CT		FLOWERY BR	GA	30542-6638
MAAS CONSTRUCTION INC	3615 SAINT ANTHONY RD		QUINCY	IL	62305-8121
MACDOUGALL PIERCE CONSTRUCTION INC	12720 FORD DR		FISHERS	IN	46038-2893
MACHINE REPAIR INTERNATIONAL	2526 MANKAS CORNER RD		FAIRFIELD	CA	94534-3134
MACON GC LLC	201 BONITA AVE		BRADFORD	IL	61421-5305
MAGNUM ELECTRIC OF MISSOURI INC	471 CHRISTIANSON DR		WEST FARGO	ND	58078-8304
MAHANEY ROOFING COMPANY INC	2822 N MEAD ST		WICHITA	KS	67219-4241
MAJOR REFRIGERATION CO INC	314 W NORTHWESTERN AVE		NORFOLK	NE	68701-6404
MANATTS INC	PO BOX 535		BROOKLYN	IA	52211-0535
MAPP CONSTRUCTION LLC	344 3RD ST		BATON ROUGE	LA	70801-1307

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MARION FIRE SPRINKLER & ALARM INC	PO BOX 386		MARION	IL	62959-0386
MASONS LANDSCAPING & CONSTRUCTION SERVICES INC	1716 TUDOR AVE		E SAINT LOUIS	IL	62207-2120
MATTCON GENERAL CONTRACTORS INC	PO BOX 98		ZIONSVILLE	IN	46077-0098
MAX TRUE FIREPROOFING CO	PO BOX 1029		JENKS	OK	74037-1029
MAXCOR INC	PO BOX 1354		PERRY	GA	31069-1354
MAYHEWS MECHANICAL COMMERCIAL REFRIGERATION INC	PO BOX 17955		N LITTLE ROCK	AR	72117-0955
MC ELECTRIC INC	7648 LL RD		RED BUD	IL	62278-2522
MCAFFEE HENDERSON SOLUTIONS INC	PO BOX 397		OSKALOOSA	KS	66066-0397
MCCLAIN & CO INCORPORATED OF VIRGINIA	19152 GERMANNA HWY		CULPEPER	VA	22701-6023
MCELROY ELECTRIC INC	3300 SW TOPEKA BLVD STE 1		TOPEKA	KS	66611-2275
MCPHERSON CONTRACTORS INC	3501 SW FAIRLAWN RD		TOPEKA	KS	66614-3976
MCSHANE CONSTRUCTION COMPANY LLC	9550 W HIGGINS RD STE 200		ROSEMONT	IL	60018-4906
MECHANICAL CONSTRUCTION SERVICES INC	PO BOX 335		NEWARK	AR	72562-0335
MERRICK UNDERGROUND CONSTRUCTION LLC	4003 DEER CROSSING DR		JANESVILLE	WI	53546-4275

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MEYER CONTRACTING	11000 93RD AVE N		MAPLE GROVE	MN	55369-4113
MEYLAN INDUSTRIAL SERVICES INC	3919 S 147TH ST STE 124		OMAHA	NE	68144-5579
MICHIGAN COMMERCIAL CONTRACTORS INC	16745 COMSTOCK ST		GRAND HAVEN	MI	49417-7949
MID AMERICA MILLING COMPANY LLC	6200 E HIGHWAY 62 UNIT 100		JEFFERSONVILLE	IN	47130-8769
MID AMERICA PIPELINE CONSTRUCTION INC	PO BOX 1830		CATOOSA	OK	74015-1830
MID SOUTH INDUSTRIAL INC	PO BOX 609		BELLS	TN	38006-0609
MID STATES INDUSTRIAL INC	519 SHIPYARD RD		SENECA	IL	61360-9203
MIDDENDORF AND REUSS CONSTRUCTION INC	800 S BREEZE STREET STE 1		WATERLOO	IL	62298
MIDLAND INDUSTRIAL SERVICE LLC	2953 S HONEYSUCKLE LN		ROGERS	AR	72758-4615
MIDLAND RESTORATION COMPANY INC	2159 INDIAN RD		FORT SCOTT	KS	66701-8732
MIDWEST COATING INC	3830 NW 16TH ST		TOPEKA	KS	66618-2846
MIDWEST COOLING TOWERS INC	1156 E HIGHWAY 19		CHICKASHA	OK	73018-6347
MIDWEST CUSTOM POOLS LLC	600 LINCOLN ST		LAWRENCE	KS	66044-5349
MIDWEST MASONRY CONSTRUCTION INC	930 E 28TH ST		LAWRENCE	KS	66046-4922
MIDWEST MECHANICAL INDUSTRIAL SERVICES	PO BOX 164		LOGAN	IA	51546-0164
MIDWEST MOLE INC	6814 W 350 N		GREENFIELD	IN	46140-9617
MIDWEST MOWING INC	2450 OWENS LN		BRIGHTON	IL	62012-1550

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MIKES HEATING AND COOLING	PO BOX 273		EAST CARONDELET	IL	62240-0273
MILESTONE CONSTRUCTION COMPANY LLC	2002 S 48TH ST		SPRINGDALE	AR	72762-5772
MILLER INSULATION CO INC	3520 E CENTURY AVE		BISMARCK	ND	58503-0739
MINERAL FABRICATION & MACHINE CO INC	PO BOX 21		KEYSER	WV	26726-0021
MINNESOTA LIMITED LLC	PO BOX 410		BIG LAKE	MN	55309-0410
MIRA ENTERPRISES	9500 IH 20		EASTLAND	TX	76448-5739
MIRON CONSTRUCTION CO INC	PO BOX 509		NEENAH	WI	54957-0509
MISSION MASONRY	7737 MISSION RD		PRAIRIE VLG	KS	66208-4231
MIXER SYSTEMS INC	PO BOX 10		PEWAUKEE	WI	53072-0010
MJM SERVICES CONSTRUCTION INC	PO BOX 24006		BELLEVILLE	IL	62223-9006
MKR SERVICES INC	3849 LAKE MICHIGAN DR NW		GRAND RAPIDS	MI	49534-4520
MLA GEOTHERMAL DRILLING LLC	205 HACKBERRY DR		GRETNA	NE	68028-4429
MODERN BUSINESS ASSOCIATES V INC	9455 KOGER BLVD N STE 200		ST PETERSBURG	FL	33702-2465
MODERN PIPING	500 WALFORD RD		CEDAR RAPIDS	IA	52404-8921
MODIFIED CONCRETE SUPPLIES LLC	6200 E HIGHWAY 62 BLDG 2501		JEFFERSONVILLE	IN	47130-8769
MOLIN CONCRETE PRODUCTS CO INC	415 LILAC ST		LINO LAKES	MN	55014-1098
MOLLERS NORTH AMERICA INC	5215 52ND ST SE		GRAND RAPIDS	MI	49512-9702

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MONTGOMERY HOFFMAN ASSOCIATES	4400 SW HOLLY LN		TOPEKA	KS	66604-1933
MOORE ASPHALT INCORPORATED	1 COMMERCIAL ST		MILLSTADT	IL	62260-2057
MORGAN HAYDEN LLC	136 HUD RD		WINCHESTER	KY	40391-9736
MORRISON BROS CONSTRUCTION COMPANY	2134 N 81ST ST		CASEYVILLE	IL	62232-1604
MORRISSEY CONTRACTING CO	PO BOX 67		GODFREY	IL	62035-0067
MOSS ROOFING & INSULATION INC	310 HIGHWAY 150 S		WEST UNION	IA	52175-1505
MOUNTAIN STATES ROOFING INC	413 E 41ST ST		GARDEN CITY	ID	83714-6310
MTD ELECTRIC LLC	22004 S WAVERLY RD		SPRING HILL	KS	66083-4548
MUELLER CONTRACTING LLC	PO BOX 10		MAEYSTOWN	IL	62256-0010
MULTATECH ENGINEERING INC	2821 W 7TH ST STE 400		FORT WORTH	TX	76107-8913
MUNICIPAL PIPE SERVICES INC	1550 NE 51ST AVE		DES MOINES	IA	50313-2123
MUNICIPAL PIPE TOOL COMPANY LLC	515 5TH ST		HUDSON	IA	50643-7773
MUNIE TRENCHING & EXCAVATING	1818 PINE ST		HIGHLAND	IL	62249-2526
MYLES LORENTZ INC	48822 OLD RIVER BLUFF RD		SAINT PETER	MN	56082-5059
NATIONAL BRIDGE	514 ANCLOTE RD		TARPON SPGS	FL	34689-6701
NATIONAL ERECTORS & BUILDERS INC	13739 KAYSER RD		HIGHLAND	IL	62249-4619

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NATIONAL ROOFING & SHEET METAL CO	G4130 FLINT ASPHALT DRIVE		BURTON	MI	48529
NATIONAL SERVICE SOLUTIONS US INC	101 GRANT WAY		MOXEE	WA	98936-9787
NATIONAL WELDING CORPORATION	7025 S COMMERCE PARK DR		MIDVALE	UT	84047-1090
NATIONWIDE FENCE & SUPPLY COMPANY	69951 LOWE PLANK RD		RICHMOND	MI	48062-5365
NBMC INC	PO BOX 300		GREENBRIER	AR	72058-0300
NEAREN CONSTRUCTION COMPANY LLC	PO BOX 2878		CULLMAN	AL	35056-2878
NELSON INDUSTRIAL SERVICES INC	6021 MELROSE LN		OKLAHOMA CITY	OK	73127-5527
NEMAHA LANDSCAPE CONSTRUCTION INC	430 W PIONEERS BLVD		LINCOLN	NE	68522-2245
NEW TECH CONSTRUCTION INC	PO BOX 39		NEBRASKA CITY	NE	68410-0039
NEW WAVE POOLS & SPAS INC	13312 GILES RD		OMAHA	NE	68138-3467
NEXT LEVEL STRATEGY LLC	1201 N RIVERFRONT BLVD STE 150		DALLAS	TX	75207-4001
NEXUS 5 GROUP LLC	6800 W 64TH ST		OVERLAND PARK	KS	66202-4100
NORMENT SECURITY GROUP INC	2511 MIDPARK RD		MONTGOMERY	AL	36109-1407
NORTH AMERICAN ROOFING SERVICES INC	14025 RIVEREDGE DR STE 600		TAMPA	FL	33637-2088
NORTH AMERICAN SUBSTATION SERVICES LLC	PO BOX 161626		ALTAMONTE SPG	FL	32716-1626
NORTH CENTRAL SERVICE INC	PO BOX 310		BEMIDJI	MN	56619-0310

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NORTH MISSISSIPPI CONVEYOR COMPANY INC	PO BOX 1375		OXFORD	MS	38655-1375
NORTHERN CLEARING INC	28190 STATE HIGHWAY 137		ASHLAND	WI	54806-4601
NORTHERN VENTURES INCORPORATED	823 OSAGE AVE		KANSAS CITY	KS	66105-1929
NORTHLAND ELECTRICAL SERVICES LLC	1705 ORVILLE DR		NEW LONDON	WI	54961-9219
NORTHSTAR DEMOLITION & REMEDIATION LP	404 N BERRY ST		BREA	CA	92821-3104
NORTHWEST AG SYSTEMS INC	2498 CARROLL AVE		SALIX	IA	51052-8097
NOVINIUM INC	22820 RUSSELL RD		KENT	WA	98032-4892
NUTRI-JECT SYSTEMS INC	PO BOX 398		HUDSON	IA	50643-0398
NWA GARAGE SOLUTIONS, INC.	PO BOX 387		ROGERS	AR	72757-0387
O AND J COATINGS INC	441 FIELDWOOD TER		HURST	TX	76053-3909
OLYMPUS PAINTING CONTRACTORS INC	556 ANCLOTE RD		TARPON SPGS	FL	34689-6701
ONEALS ELECTRIC HEATING & COOLING INC	2700 BAUGHMAN CUTOFF RD		HARRISON	AR	72601-6720
ORASURE TECHNOLOGIES INC	220 E 1ST ST		BETHLEHEM	PA	18015-1360
OSMENT ROOFING SYSTEMS INC	4201 E NETTLETON AVE		JONESBORO	AR	72401-5560
OTC SERVICES INC	PO BOX 188		LOUISVILLE	OH	44641-0188
OTTO BAUM COMPANY INC	866 N MAIN ST		MORTON	IL	61550-1645
OUTDOOR SYSTEMS INC	660 STATE ROUTE 158		COLUMBIA	IL	62236-3232
P&P ARTEC INC	700 CREEL DR		WOOD DALE	IL	60191-2608

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PACIFIC TECH CONSTRUCTION, INC.	1302 WALNUT ST		KELSO	WA	98626-2719
PAINT PRO OF MISSOURI INC	6930 W 152ND TER		OVERLAND PARK	KS	66223-3125
PAR RESTORATION SERVICES INC	120 S CENTRAL AVE		CLAYTON	MO	63105-1705
PARAGON INTERNATIONAL INC	2885 N BERKELEY LAKE RD NW STE 17		DULUTH	GA	30096-4343
PARK CONSTRUCTION MIDWEST INC	1481 81ST AVE NE		MINNEAPOLIS	MN	55432-1795
PARKWAY C&A LP	1000 CIVIC CIR		LEWISVILLE	TX	75067-3493
PARSONS PROJECT SERVICES INC	16055 SPACE CENTER BLVD STE 725		HOUSTON	TX	77062-6269
PARTLAN-LABADIE SHEET METAL CO.	12901 CLOVERDALE ST		OAK PARK	MI	48237-3205
PATRIOT DRYWALL COMPANY INC	19925 W 161ST ST STE B		OLATHE	KS	66062-2788
PAULON CONSTRUCTION MANAGEMENT CORP	13189 OYSTER LAKE RD		HOLLY	MI	48442-7903
PAVEMENT SERVICES CORPORATION	PO BOX 1107		EULESS	TX	76039-1107
PAVEWAY SYSTEMS INC	114 INDIAN LAKES LN		FLORAHOME	FL	32140-3614
PAYNE CONSTRUCTION SERVICES LLC	10565 DOWNTOWN LN		BUNKER HILL	IL	62014-2855
PCF CONSTRUCTION CO INC	1311 CART RD		BELLEVILLE	IL	62221-2465
PEERLES COMPACTION GROUTING INC	1200 SW BROOKSIDE CIR STE 15		GRIMES	IA	50111-5141
PERFECT PLAY FIELDS AND LINKS INC	PO BOX 24006		BELLEVILLE	IL	62223-9006
PERFECTION ELECTRIC INC	615 MILL CREEK FARMS RD		TROY	IL	62294-2622

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PERFORMANCE CONTRACTORS INC	PO BOX 83630		BATON ROUGE	LA	70884-3630
PERRETT CONSTRUCTION LTD	PO BOX 32		VALENTINE	NE	69201-0032
PETREE CONSTRUCTION	1100 S D ST		FORT SMITH	AR	72901-4510
PETTUS PLUMBING & PIPING INC	PO BOX 1048		ROGERSVILLE	AL	35652-1048
PFEFFERKORN & DRURY CONSTRUCTION LLC	PO BOX 448		PAOLA	KS	66071-0448
PHOENIX MODULAR ELEVATOR	4800 PHOENIX DR		MOUNT VERNON	IL	62864-4212
PINNACLE CONSTRUCTION OF IOWA INC	PO BOX 368		GLENWOOD	IA	51534-0368
PINNACLE MECHANICAL	PO BOX 133		HORTON	AL	35980-0133
PIPING CONTRACTORS OF KANSAS INC	115 SW JACKSON ST		TOPEKA	KS	66603-3311
PISHNY REAL ESTATE SERVICES LLC	12202 W 88TH ST		LENEXA	KS	66215-4607
PITRE CONSTRUCTION INC	6835 TOWN HALL RD		BELLEVILLE	IL	62223-8623
PLANT MAINTENANCE SERVICE CORPORATION	3000 FITE RD		MILLINGTON	TN	38053-8334
PLYLERS AT YOUR SERVICE INC	10 CREEK ST		BROOKVILLE	PA	15825-1401
P-N-G CONTRACTING INC	917 CARLA DR		TROY	IL	62294-3153
POLY VINYL ROOFING INC	785 ELBOW CREEK RD		MOUNT VERNON	IA	52314-9732
PORTERS COMMERCIAL REFRIGERATION INC	118 RIDGE DR		GREENBRIER	AR	72058-9652
POWER HOME TECHNOLOGIES, LLC	4521 PRESLYN DR		RALEIGH	NC	27616-3178

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POWERSECURE INC	1609 HERITAGE COMMERCE CT		WAKE FOREST	NC	27587-4245
PRAIRIE CENTER PLUMBING HEATING & AIR CONDITIONING	242 N MARION ST		OLATHE	KS	66061-3105
PRAIRIE CONTRACTORS INC	9318 GULFSTREAM RD STE C		FRANKFORT	IL	60423-2538
PRECISION UTILITIES GROUP INC	5916 E STATE BLVD		FORT WAYNE	IN	46815-7637
PREDICTIVE TECHNOLOGIES INC	18827 570TH AVE		AUSTIN	MN	55912-5986
PREFERRED GLOBAL INC	1360 S 10TH ST		NOBLESVILLE	IN	46060-3828
PRELOAD LLC	4000 TOWER RD		LOUISVILLE	KY	40219-1901
PREMIER SITE SERVICES LLC	100 BRICKERTON ST		COLUMBUS	MS	39701-3608
PREMIER STEEL INC	3248 MARTIN LUTHER KING		ANDERSON	IN	46013
PREMIER WORKFORCE INC	18708 W CATAWBA AVE # 1		CORNELIUS	NC	28031-5615
PRO ALARM LLC	130 N DUNCAN ST		MARINE	IL	62061
PROBST ELECTRIC INC	441 W POWERLINE RD		HEBER CITY	UT	84032-1277
PROCESS EQUIPMENT INC	PO BOX 1607		PELHAM	AL	35124-5607
PROCESS SOLUTIONS INC	1077 DELL AVE STE A		CAMPBELL	CA	95008-6628
PROGRESS CONSTRUCTION OF MISSISSIPPI INC	180 GOODMAN ROAD		SOUTHHAVEN	MS	38671
PROGRESSIVE PLUMBING & PIPING INC	6007 W 8000 S		PAYSON	UT	84651-9724
PROSHOT CONCRETE INC	4158 MUSGROVE DR		FLORENCE	AL	35630-6396
PROSSER WILBERT CONSTRUCTION INC	13730 W 108TH ST		LENEXA	KS	66215-2026

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Contractor Name	Street Address	Street Address 2	City	State	Zip Code
PSF MECHANICAL INC	11621 E MARGINAL WAY S # A		TUKWILA	WA	98168-1965
PSI PROFESSIONAL SURFACE INSTALLATIONS INC	3440 MARINATOWN LN STE 205		N FORT MYERS	FL	33903-7049
Q AND D CONSTRUCTION INC	PO BOX 10865		RENO	NV	89510-0835
Q3 CONTRACTING INC	3066 SPRUCE ST		LITTLE CANADA	MN	55117-1061
QCI THERMAL SYSTEMS INC	PO BOX 2432		DAVENPORT	IA	52809-2432
QUAD COUNTY AG LLC	PO BOX 216		PATON	IA	50217-0216
QUALITY ELECTRIC OF DOUGLAS COUNTY INC	1011 E 31ST ST		LAWRENCE	KS	66046-5103
QUALITY POLE INSPECTION & MAINTENANCE INC	PO BOX 947		EDNA	TX	77957-0947
QUALITY SAW & SEAL INC	7600 W 79TH ST STE 2		BRIDGEVIEW	IL	60455-2505
QUALITY STRIPING INC	1704 E EUCLID AVE		DES MOINES	IA	50313-4730
QUANDEL ENTERPRISES INC	3003 N FRONT ST		HARRISBURG	PA	17110-1224
RAGNAR BENSON LLC	PO BOX 2071		LOVES PARK	IL	61130-0071
RAGSDALE CONSTRUCTION	5324 WYNNEFORD WAY		RALEIGH	NC	27614-9817
RAMON J GARCIA CONSTRUCTION	3315 N 115TH ST		KANSAS CITY	KS	66109-3404
RAMPART HYDRO SERVICES LP	530 MOON CLINTON RD STE 4		CORAOPOLIS	PA	15108-3874
RANGER PLANT CONSTRUCTIONAL CO INC	5851 E INTERSTATE 20		ABILENE	TX	79601-7625
RAPID MOLD REMOVAL, LLC	2607 EATON RAPIDS RD		LANSING	MI	48911-6310
RAWLINGS INDUSTRIAL INC	PO BOX 1438		HAMILTON	MT	59840-1438

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RE CON COMPANY A TEXAS CORP	12 NE 52ND ST		OKLAHOMA CITY	OK	73105-1888
RECTENWALD BROTHERS CONSTRUCTION INCORPORATED	16 LEONBERG RD		CRANBERRY TWP	PA	16066-3602
REED DILLON & ASSOCIATES LLC	1213 E 24TH ST		LAWRENCE	KS	66046-5128
RELIABLE RELAMPING INC	6459 NASH RD		SARANAC	MI	48881-9608
RELIA TECH INC	2280 SIBLEY CT		EAGAN	MN	55122-1998
REMBCO GEOTECHNICAL CONTRACTORS INC	PO BOX 23009		KNOXVILLE	TN	37933-1009
RENIER CONSTRUCTION CORPORATION	2164 CITYGATE DR		COLUMBUS	OH	43219-3556
RETAIL CONSTRUCTION SERVICES INC	11343 39TH ST N		LAKE ELMO	MN	55042-9586
RETAIL STOREFRONT GROUP INC	PO BOX 1070		LEEDS	AL	35094-0020
RFB CONSTRUCTION CO INC	565 E 520TH AVE		PITTSBURG	KS	66762-6829
RHODEN ROOFING LLC	358 S LAURA ST		WICHITA	KS	67211-1517
RICHARD NACHBAR PLUMBING INC	9053 COTTONWOOD CANYON PL		LENEXA	KS	66219-8174
RICHARDSON TURNER CONSTRUCTION COMPANY INC	10425 COGDILL RD STE 100		KNOXVILLE	TN	37932-3391
RIEKE GRADING INC	8200 HEDGE LANE TER		SHAWNEE	KS	66227-3037
RIGHT WAY FACILITY SERVICES OF TEXAS LLC	503 MERCEDES ST STE B		BENBROOK	TX	76126-2572
RITEWAY CONVEYORS INC	2364 HIGHWAY 7		LESTER PRAIRIE	MN	5535

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RJ MARTIN NATIONAL CONTRACTING INC	22841 AURORA RD		BEDFORD HTS	OH	44146-1244
RJ MECHANICAL INC	3153 BELWOOD DR		VESTAVIA	AL	35243-5216
RL BISHOP & ASSOCIATES INC	PO BOX 703		MANCHESTER	GA	31816-0703
RL COOLSAET CONSTRUCTION COMPANY	PO BOX 279		TAYLOR	MI	48180-0279
RMS CRANES LLC	1900 E 66TH AVE		DENVER	CO	80229-7424
ROCK REMOVAL RESOURCES LLC	1125 N MILITARY AVE		GREEN BAY	WI	54303-4413
ROCKFORD CONSTRUCTION COMPANY	601 1ST ST NW		GRAND RAPIDS	MI	49504-5517
ROEHL REFRIGERATED TRANSPORT LLC	PO BOX 750		MARSHFIELD	WI	54449-0750
ROLLING PLAINS CONSTRUCTION INC	12331 PEORIA ST		HENDERSON	CO	80640-9650
RON'S SIGN COMPANY	1329 S HANDLEY ST		WICHITA	KS	67213-4316
ROPE PARTNER INC	125 MCPHERSON ST STE B		SANTA CRUZ	CA	95060-5883
ROYAL ROOFING COMPANY INC	2445 BROWN RD		ORION	MI	48359-1810
ROYAL SEAL CONSTRUCTION INC	124 MCMAKIN RD		BARTONVILLE	TX	76226-8499
ROYALTY COMPANIES OF INDIANA INC	2099 E TIPTON ST		SEYMOUR	IN	47274-3567
RP COATINGS INC	PO BOX 327		TROY	IL	62294-0327
RYAN & ASSOCIATES INC	10955 160TH ST		DAVENPORT	IA	52804-9166
RYAN CONTRACTORS INC	9390 7TH ST STE A		RCH CUCAMONGA	CA	91730-5669

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RYAN INCORPORATED CENTRAL	PO BOX 206		JANESVILLE	WI	53547-0206
S & K REECE CONSTRUCTION LLC	11501 W 109TH ST		OVERLAND PARK	KS	66210-1235
S & W CONSTRUCTION LLC OF IOWA	109 MOODY DR		HAMBURG	IA	51640-1803
S T COTTER TURBINE SERVICES INC	2167 196TH ST E		CLEARWATER	MN	55320-1660
SAAB NORTH AMERICA INC	20700 LOUDOUN COUNTY PKWY STE 152		ASHBURN	VA	20147-2930
SAMRON MIDWEST CONTRACTING INC	PO BOX 1555		MURPHYSBORO	IL	62966-5055
SARENS	5000 EXECUTIVE PKWY STE 230		SAN RAMON	CA	94583-4341
SATELLITE SERVICES INC	309 S FRONT ST		MARQUETTE	MI	49855-4600
SCHECK TECHNICAL SERVICES INC	1 E OAKHILL DR STE 100		WESTMONT	IL	60559-5540
SCHEINER COMMERCIAL GROUP INC	18965 BASE CAMP RD STE A- 1		MONUMENT	CO	80132-8067
SCHERZINGER DRILLING INC	PO BOX 202		MIAMITOWN	OH	45041-0202
SCHLEIS FLOOR COVERING INC	998 GLORY RD		GREEN BAY	WI	54304-5631
SCHUFF STEEL COMPANY	PO BOX 19028		PHOENIX	AZ	85005-9028
SCHULTZ BROTHERS ELECTRIC CO INC	3030 S 24TH ST # A		KANSAS CITY	KS	66106-4707
SCHUMACHER ELEVATOR COMPANY	1 SCHUMACHER WAY		DENVER	IA	50622-7729
SCHUPPS LINE CONSTRUCTION INC	PO BOX 13655		ALBANY	NY	12212-3655

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SCHWEITZER ENGINEERING LABORATORIES INC	2440 NE HOPKINS CT		PULLMAN	WA	99163-5616
SCHWICKERTS TECTA AMERICA LLC	PO BOX 1179		MANKATO	MN	56002-1179
SCS CONSTRUCTION SERVICES INCORPORATED	156 S PARK BLVD		GREENWOOD	IN	46143-8837
SEAKAY CONSTRUCTION SE CORP	19001 BUCKLODGE RD		BOYDS	MD	20841-9536
SEAMLESS SOLUTIONS LLC	12605 W SANTA FE TRAIL DR		LENEXA	KS	66215
SECURICON LLC	5400 SHAWNEE RD STE 206		ALEXANDRIA	VA	22312-2300
SECURITAS ELECTRONIC SECURITY INC	3800 TABS DR		UNIONTOWN	OH	44685-9564
SEELE INC	24 W 40TH ST FL 12		NEW YORK	NY	10018-1094
SEK HEAT & AIR INC	422 W ATKINSON RD		PITTSBURG	KS	66762-8634
SELECT TECHNOLOGIES INC	8093 GRAPHIC DR NE		BELMONT	MI	49306-9448
SEMA CONSTRUCTION INC	7353 S EAGLE ST		ENGLEWOOD	CO	80112-4223
SEMINOLE EQUIPMENT INC	204 TARPON INDUSTRIAL DR		TARPON SPGS	FL	34689-6801
SERVICE & INDUSTRIAL REPAIR INC	18097 VAIL RD		PLEASANTON	KS	66075-7503
SES INFRASTRUCTURE SERVICES LLC	1006 FLOYD CULLER CT STE 6		OAK RIDGE	TN	37830-8022
SEVEN25 LLC	12080 DURBIN DR		CARMEL	IN	46032-8939
SG CONSTRUCTION SERVICES LLC	111 E COURT ST STE 1A		FLINT	MI	48502-1649
SHADE STRUCTURES INC	8505 CHANCELLOR ROW		DALLAS	TX	75247-5519
SHAFFER ENTERPRISES D & T LLC	301 LEONA LN		URSA	IL	62376-1119

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SHEET PILING SERVICES LLC	6872 STATE HIGHWAY 66		CUSTER	WI	54423-9608
SHERMCO INDUSTRIES INC	PO BOX 540545		DALLAS	TX	75354-0545
SHORTRIDGE CONSTRUCTION COMPANY, INC	3908 N 24TH ST		QUINCY	IL	62305-9628
SIERRA BRAVO CONTRACTORS LLC	7038 STATE HIGHWAY 154		SESSER	IL	62884
SIGN CRAFTERS INC	1508 STRINGTOWN RD		EVANSVILLE	IN	47711-4593
SIGN ME UP OF WISCONSIN LLC	3111 FOREST AVE		SHEBOYGAN FLS	WI	53085-2526
SIMBECK & ASSOCIATES INC	38256 HIGHWAY 160		MANCOS	CO	81328-8967
SIMON ROOFING AND SHEET METAL CORP	70 KARAGO AVE		YOUNGSTOWN	OH	44512-5949
SKYLINE TECHNOLOGY SOLUTIONS	6956F AVIATION BLVD		GLEN BURNIE	MD	21061-2531
SKYTOP TOWERS INC	13503 W US HIGHWAY 34		MALCOLM	NE	68402-9783
SLAYDEN GLASS INC	239 N OLD SAINT LOUIS RD		WOOD RIVER	IL	62095-1437
SMITH TANK & STEEL INC	PO BOX 2370		GONZALES	LA	70707-2370
SMITHSON INC	PO BOX 1731		ROCKY MOUNT	NC	27802-1731
SNELL NORTHCUIT ELECTRIC INC	P O BOX 24601		LITTLE ROCK	AR	72221
SNELSON COMPANIES INC	601 W STATE ST		SEDRO WOOLLEY	WA	98284-1560
SOLARIS ROOFING SOLUTIONS INC	31W023 NORTH AVE		WEST CHICAGO	IL	60185-1060
SOLID PLATFORMS INC	6610 MELTON RD		PORTAGE	IN	46368-1236
SORELLA GROUP	14844 W 107TH ST		LENEXA	KS	66215-4002

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SOUTHEAST DIRECTIONAL DRILLING LLC	3117 N CESSNA AVE		CASA GRANDE	AZ	85122-7947
SOUTHEAST POWER CORPORATION	1684 W HIBISCUS BLVD		MELBOURNE	FL	32901-2631
SOUTHERN ENVIRONMENTAL INC	6540 W NINE MILE RD		PENSACOLA	FL	32526-4288
SOUTHERN ERECTORS INC	6540 W NINE MILE RD		PENSACOLA	FL	32526-4288
SOUTHERN MARINE CONSTRUCTION CO	PO BOX 4539		CHATTANOOGA	TN	37405-0539
SOUTHWEST FIXTURE INSTALLERS INC	15600 28TH AVE N		PLYMOUTH	MN	55447-1903
SOVEREIGN STAFFING GROUP INC	15024 W 117TH ST		OLATHE	KS	66062-9308
SOWARDS GLASS, INC	2011 NW TOPEKA BLVD		TOPEKA	KS	66608-1828
SPARROW PLUMBING & HEATING INC	313 DELAWARE ST		QUINCY	IL	62301-4823
SPECPRO INCORPORATED OF NEBRASKA	309 E 2ND ST STE 4		PAPILLION	NE	68046-2469
SPECTRA TECH LLC	10340 PLEASANT ST STE 100		NOBLESVILLE	IN	46060-3947
SPORTS METALS INC	PO BOX 1338		PHENIX CITY	AL	36868-1338
SSI INCORPORATED OF NW ARKANSAS	2817 YUMA ST		FORT SMITH	AR	72901-8778
STAKE CENTER LOCATING INC	2920 W DIRECTORS ROW		SALT LAKE CTY	UT	84104-4549
STANDARD CARTAGE CO INC	2400 S 27TH AVE		BROADVIEW	IL	60155-3853
STANLEY STEEMER	1021 FOSSE RD UNIT A		OTTAWA	IL	61350-9364
STARR HOMES LLC	7555 W 160TH ST		STILWELL	KS	66085-8101

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STEPHENS & SMITH CONSTRUCTION CO INC	1542 S 1ST ST		LINCOLN	NE	68502-1999
STERLING PIPELINE SOLUTIONS LLC	501 E 151ST ST		PHOENIX	IL	60426-2402
STEVE HOEGGER & ASSOCIATES INC	2630 N HIGHWAY 78		WYLLIE	TX	75098-6055
STILL CONTRACTORS LLC	15740 S MAHAFFIE ST		OLATHE	KS	66062-4038
STILTNER ELECTRIC INC	340 HERKY ST		NORTH LIBERTY	IA	52317-8523
STIREK CONSTRUCTION SERVICES INC	PO BOX 10		BLAIR	NE	68008-0010
STONEBRIDGE CONSTRUCTION LLC	PO BOX 16787		JONESBORO	AR	72403-6712
STORY CONSTRUCTION CO	2810 WAKEFIELD CIR		AMES	IA	50010-7725
STRATEGIAN VENTURES LLC	5411 PLAZA DR		TEXARKANA	TX	75503-1666
STRINGER CONSTRUCTION COMPANY INC	6141 LUCILLE LN		SHAWNEE	KS	66203-2609
STRUCTURAL GROUP INC	10150 OLD COLUMBIA RD		COLUMBIA	MD	21046-1274
STRUCTURAL RESTORATION INC	305 3RD ST		FARMINGTON	MN	55024-1352
STRUCTURAL WATERPROOFING INC	PO BOX 255		FARMINGTON	MN	55024-0255
SUMMIT HEARTLAND LLC	3823 W 1800 S		REMINGTON	IN	47977-8831
SUMMIT REFRIGERATION GROUP INC	W141N9501 FOUNTAIN BLVD		MENOMONEE FALLS	WI	53051-1623
SUNBELT FIRE PROTECTION INC	1520 S MEMORIAL DR		TULSA	OK	74112-7039
SUNLAND CONSTRUCTION INC	PO BOX 1087		EUNICE	LA	70535-1087

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SUPER SKY PRODUCTS ENTERPRISES LLC	10301 N ENTERPRISE DR		MEQUON	WI	53092-4639
SUPREME ELECTRIC CO	PO BOX 114		QUINCY	IL	62306-0114
SURE STEEL INC	7528 CORNIA DR		SOUTH WEBER	UT	84405-9605
SURFACE AMERICA INC	PO BOX 157		WILLIAMSVILLE	NY	14231-0157
SURFACE PREPARATION TECHNOLOGIES LLC	81 TEXACO RD		MECHANICSBURG	PA	17050-2623
SUTTERFIELD ELECTRIC CONTRACTING CORP	114 1ST AVE		EDWARDSVILLE	IL	62025-2574
SWIFT ROOFING INC	PO BOX 1102		MURRAY	KY	42071-0020
SYSTEMS PLANT SERVICES INC	214 N WASHINGTON AVE STE 700		EL DORADO	AR	71730-5659
T & G CONSTRUCTION OF STILLWATER INC	5620 MEMORIAL AVE N STE H		STILLWATER	MN	55082-1052
T WINN CONSTRUCTION COMPANY	15018 A CIR		OMAHA	NE	68144-5558
TANCO ENGINEERING INCORPORATED	1400 TAURUS CT		LOVELAND	CO	80537-3297
TANK BUILDERS INC	PO BOX 1527		EULESS	TX	76039-1527
TANK FOUNDATIONS INC	410 W FRONT ST		LAKE MILLS	IA	50450-1109
TATE GENERAL CONTRACTORS INC	115 WOODY LN		JONESBORO	AR	72401-0496
TATE ORNAMENTAL INC	496 SAGE RD N		WHITE HOUSE	TN	37188-8174
TAYLOR BROS CONSTRUCTION CO INC	4555 MIDDLE RD		COLUMBUS	IN	47203-1834
TCI SERVICES INCORPORATED	4333 W 21ST ST		TULSA	OK	74107-3444
TCR SYSTEMS	PO BOX 3988		DECATUR	IL	62524

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TDR CONTRACTORS INC	PO BOX 1003		GILMER	TX	75644-1003
TEKRAN INSTRUMENTS CORPORATION	230 TECH CENTER DR		KNOXVILLE	TN	37912-2747
TELECOM SOLUTIONS MIDWEST LLC	85 CARDINAL TRL		POCAHONTAS	AR	72455-5424
TELLUS LLC	829 NANCY LYNN LN		ARNOLD	MD	21012-3025
TENNESSEE ELECTRIC COMPANY INC	1025 KONNAROCK RD		KINGSPORT	TN	37664-3720
TERRAZZO USA AND ASSOCIATES INC	9532 TOWRY CT		OKLAHOMA CITY	OK	73165-4629
TEXAS ALLIANCE GROUP INC	11288 WEST RD		HOUSTON	TX	77065-4493
TEXOMA INDUSTRIAL INSULATION ASSOCIATION	PO BOX 497		DENISON	TX	75021-0497
TG MERCER CONSULTING SERVICES INC	120 EL CHICO TRL		WILLOW PARK	TX	76087-8865
THE DRILLER LLC	5125 E UNIVERSITY AVE		PLEASANT HILL	IA	50327-7007
THE FISHEL COMPANY	1366 DUBLIN RD		COLUMBUS	OH	43215-1093
THE FORREST GROUP LTD	2108 N 129TH EAST AVE		TULSA	OK	74116-1729
THE FRED CHRISTEN & SONS COMPANY	PO BOX 547		TOLEDO	OH	43697-0547
THE KILIAN CORPORATION	PO BOX A		MASCOUTAH	IL	62258-0187
THE MAXIS GROUP INC	8225 E DEL CAMINO DR # 100		SCOTTSDALE	AZ	85258-2330
THE RECOVERY TEAM LLC	3150 ROGERS RD STE 202		WAKE FOREST	NC	27587-4196
THE REDMOND COMPANY	W228N745 WESTMOUND DR		WAUKESHA	WI	53186-1654
THE RIVERSIDE GROUP INC	13238 S PEORIA AVE		BIXBY	OK	74008-4846

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THE ROBINS & MORTON GROUP	PO BOX 59289		BIRMINGHAM	AL	35259-9289
THE WEITZ CONSTRUCTION COMPANY INC	420 WATSON POWELL PKWY STE 100		DES MOINES	IA	50309-1611
THIELSCH ENGINEERING INC	195 FRANCES AVE		CRANSTON	RI	02910-2211
THIRKETTLE CORPORATION	6700 GUADA COMA DR		SCHERTZ	TX	78154-3247
THOMAS GRACE CONSTRUCTION INC	5605 MEMORIAL AVE N		STILLWATER	MN	55082-1092
THOMPSON ELECTRIC COMPANY	3505 S 61ST AVENUE CIR		OMAHA	NE	68106-4306
THOMPSON THRIFT CONSTRUCTION INC	901 WABASH AVE STE 300		TERRE HAUTE	IN	47807-3233
TINDALL CONTRACTOR INC	5240 NAMEOKI RD		PONTOON BEACH	IL	62040-2656
TITAN CONTRACTING & LEASING CO INC	2205 RAGU DR		OWENSBORO	KY	42303-1437
TOMS TUCKPOINTING LLC	202 W BROADWAY ST		POCAHONTAS	AR	72455-3419
TOTAL ELECTRIC CONTRACTORS INC	PO BOX 13247		EDWARDSVILLE	KS	66113-0247
TOUCH UP PLUS	5353 SPRINGFIELD DR		EDWARDSVILLE	IL	62025-5835
TOURNEAR ROOFING CO	2605 SPRING LAKE RD		QUINCY	IL	62305-0523
TOWER TECHNOLOGIES GROUP LLC	PO BOX 266		EDGERTON	WI	53534-0266
TRADEMARK RESTORATION INCORPORATED	6260 E RIVERSIDE BLVD # 163		LOVES PARK	IL	61111-4418
TRI CITY ELECTRIC COMPANY OF IOWA	6225 N BRADY ST		DAVENPORT	IA	52806-0002
TRI COUNTY WELDING & FABRICATION	PO BOX 137		ARTHUR	IL	61911-0137

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TRI NORTH BUILDERS INC	PO BOX 259568		MADISON	WI	53725-9568
TRI STATE CONCRETE CORRECTION CO	3215 CORONA RD		QUINCY	IL	62305-8131
TRITECHNE CONSTRUCTION & INSTALLATION INC	2655 DONAGHEY AVE STE 3		CONWAY	AR	72032-2317
TROCIN INC	1901 MARTIN RD		DRIPPING SPGS	TX	78620-3507
TRUCK CRANE SERVICE COMPANY	PO BOX 21388		SAINT PAUL	MN	55121-0388
TUCKER CONSTRUCTION CO	PO BOX 442		LINDSAY	OK	73052
TUCKER TECHNOLOGY INC	300 FRANK H OGAWA PLZ STE 210		OAKLAND	CA	94612-2060
TUFF WRAP INSTALLATIONS INC	2080 DETWILER RD STE 2		HARLEYSVILLE	PA	19438-2911
TUNISTA CONSTRUCTION LLC	PO BOX 70668		FAIRBANKS	AK	99707-0668
TURF DESIGN INC	PO BOX 860303		SHAWNEE	KS	66286-0303
TURNER CERAMIC TILE INC	11535 KAW DR		KANSAS CITY	KS	66111-1111
TUTTLE INC	110 PAGE ST		FRIEND	NE	68359-1147
TWEET GAROT MECHANICAL INC	325 REID ST		DE PERE	WI	54115-2130
TYROLT INCORPORATED	724 N MERCER ST		DECATUR	IL	62522-1699
U S ELECTRICAL CONSTRUCTION CO INC	79 S MAIN ST		MULLICA HILL	NJ	08062-9711
U.S. GENERAL CONSTRUCTION, INC.	PO BOX 304		ALPHARETTA	GA	30009-0304
UCI INC	PO BOX 9592		WICHITA	KS	67277-0592
UDIG LLC	8000 FRANKLIN FARMS DR STE 100		HENRICO	VA	23229-5002

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ULTIMATE THERMAL INC	PO BOX 34818		OMAHA	NE	68134-0818
ULTRAFLOTE LLC	3640 W 12TH ST		HOUSTON	TX	77008-6050
UNITED CONSTRUCTION COMPANY	PO BOX 4408		DAVENPORT	IA	52808-4408
UNITED GOLF LLC	2108 N 129TH EAST AVE		TULSA	OK	74116-1729
UNITED PIPING INC	4510 AIRPORT RD		DULUTH	MN	55811-1523
UNITED STATES CONSTRUCTION LLC	5845 HORTON ST STE 203		MISSION	KS	66202-2610
UNIVERSAL COMMUNICATIONS LLC	19915 W 161ST ST STE E		OLATHE	KS	66062-2762
UNIVERSAL SERVICES TELECOMMUNICATIONS TECHS INC	12151 120TH ST S		HASTINGS	MN	55033-9428
UNIVERSAL WALL SYSTEMS INC	4400 DONKERS CT SE		GRAND RAPIDS	MI	49512-4054
UPCHURCH PLUMBING INC	PO BOX 8106		GREENWOOD	MS	38935-8106
URETEK USA INC	PO BOX 1929		TOMBALL	TX	77377-1929
USC LLC	2320 124TH RD		SABETHA	KS	66534-9459
UTILITY SOLUTIONS LLC	14612 PARALLEL LN		BASEHOR	KS	66007-4001
UTILITY SYSTEMS SOLUTIONS INC	14330 MIDWAY RD STE 200		DALLAS	TX	75244-3501
VAN ERT ELECTRIC COMPANY INC	7019 STEWART AVE		WAUSAU	WI	54401-9230
VCC LLC	PO BOX 2558		LITTLE ROCK	AR	72203-2558
VEIT AND COMPANY INC	14000 VEIT PL		ROGERS	MN	55374-9306
VENTURE CONSTRUCTION WATERPROOFING INC	42 LOCKE RD		CONCORD	NH	03301-5416

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Missouri Department of Revenue

EI0130

Taxation Division

Show Secretary of State Cover: Yes

Construction Transient Employer Listing

Contractor Name	Street Address	Street Address 2	City	State	Zip Code
VETERANS RANGE SOLUTIONS LLC	27840 COUNTY ROUTE 193 STE 2		THERESA	NY	13691-4016
VIACON INC	70 BANKS RD		STOCKBRIDGE	GA	30281-4362
VICTORY AIR INC	853 S KEIFER ST		BENNETT	CO	80102-8733
VIKING ERECTORS CORP	PO BOX 1336		MC MURRAY	PA	15317-4336
VISIONSOFT INTERNATIONAL INC	1842 OLD NORCROSS RD STE 100		LAWRENCEVILLE	GA	30044-8802
VISU SEWER INC	W230N48557 BETKER RD		PEWAUKEE	WI	53072
VIVAX SYSTEMS INC	1050 YUMA ST		DENVER	CO	80204-3838
VKW CONSTRUCTION LLC	505 S MADISON DR		TEMPE	AZ	85281-7213
WADES REFRIGERATION INC	PO BOX 2164		BATESVILLE	AR	72503-2164
WAFFLE HOUSE INC	PO BOX 6450		NORCROSS	GA	30091-6450
WALTERS CARPENTRY INC	2340 SHEPLER CHURCH AVE SW		CANTON	OH	44706-5615
WATSON ELECTRIC INC	318 N 8TH ST		SALINA	KS	67401-2312
WATTS ELECTRIC COMPANY	13351 DOVERS ST		WAVERLY	NE	68462-2516
WEATHERCRAFT COMPANY OF GRAND ISLAND	323 N CLEBURN ST		GRAND ISLAND	NE	68801-4705
WEATHERCRAFT COMPANY OF LINCOLN	PO BOX 80459		LINCOLN	NE	68501-0459
WEEKES CONSTRUCTION INC	PO BOX 17977		GREENVILLE	SC	29606-8977
WESTERN OILFIELDS SUPPLY COMPANY	PO BOX 2248		BAKERSFIELD	CA	93303-2248
WHEATLAND CONTRACTING LLC	6204 246TH RD		EFFINGHAM	KS	66023-5151
WIGINTON CORPORATION	699 AERO LN		SANFORD	FL	32771-6699

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Missouri Department of Revenue

Taxation Division

EI0130

Show Secretary of State Cover: Yes

Construction Transient Employer Listing

Contractor Name	Street Address	Street Address 2	City	State	Zip Code
WILLIAM G CURTH INC	PO BOX 3463		SHAWNEE	KS	66203-0463
WILLIAMS ELECTRIC CO INC	695 DENTON BLVD NW		FT WALTON BCH	FL	32547-2150
WILSONS POOLS PLUS INC	843 SCOTT TROY RD		LEBANON	IL	62254-1911
WINGER CONTRACTING COMPANY	PO BOX 637		OTTUMWA	IA	52501-0637
WOLF CONSTRUCTION INC	5630 SW RANDOLPH AVE		TOPEKA	KS	66609-1158
WOLTCOM INC	2300 TECHNOLOGY PKWY STE 8		HOLLISTER	CA	95023-2536
WOODS BASEMENT SYSTEMS INC	524 VANDALIA ST		COLLINSVILLE	IL	62234-4041
WORLDWIDE TURBINES LLC	1001 YAMATO RD STE 312		BOCA RATON	FL	33431-4403
WR NEWMAN & ASSOCIATES INC	2854 LOGAN ST		NASHVILLE	TN	37211-2409
WS INDUSTRIAL SERVICES INC	35 MAIN PL STE 175		COUNCIL BLFS	IA	51503-0708
W-S SPECIALTY SERVICES LLC	35 MAIN PL STE 175		COUNCIL BLFS	IA	51503-0708
WSI INC	PO BOX 263		VALMEYER	IL	62295-0263
WVP INSTALLATIONS INC	7317 MAPLE AVE		CINCINNATI	OH	45231-4233
WYOMING EFFICIENCY CONTRACTORS INC	530 E COSTILLA ST		COLORADO SPGS	CO	80903-3763
XL INDUSTRIAL SERVICES INC	1920 N 400 W		LA PORTE	IN	46350-2131
YOKOGAWA CORPORATION OF AMERICA	2 DART RD		NEWNAN	GA	30265-1094
YOTHER CONSTRUCTION MANAGEMENT INCORPORATED	PO BOX 2208		CAREFREE	AZ	85377-2208

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Missouri Department of Revenue

EI0130

Taxation Division

Show Secretary of State Cover: Yes

Construction Transient Employer Listing

Contractor Name	Street Address	Street Address 2	City	State	Zip Code
ZAPATA INCORPORATED	6302 FAIRVIEW RD STE 600		CHARLOTTE	NC	28210-2244
ZEAMERS WELDING LLC	2772 BLAKE RD E		DE PERE	WI	54115-8720
ZERNCO INC	2400 S GREENWICH RD		WICHITA	KS	67210-1813
ZIEGENFUSS DRILLING INC	PO BOX 308		RINGOES	NJ	08551-0308
ZIMMERMAN CONSTRUCTION COMPANY INC	12509 HEMLOCK ST		OVERLAND PARK	KS	66213-1453

The Secretary of State is required by sections 347.141 and 359.481, RSMo 2016, to publish dissolutions of limited liability companies and limited partnerships. The content requirements for the one-time publishing of these notices are prescribed by statute. This listing is published pursuant to these statutes. We request that documents submitted for publication in this section be submitted in camera ready 8 1/2" x 11" manuscript by email to adrules.dissolutions@sos.mo.gov.

**NOTICE OF WINDING UP
OF LIMITED LIABILITY COMPANY
TO ALL CREDITORS OF
AND CLAIMANTS AGAINST
769 SPIRIT, LLC**

On October 11, 2018, 769 SPIRIT, LLC, a Missouri limited liability company, filed a Notice of Winding Up for Limited Liability Company with the Missouri Secretary of State.

Persons with claims against the limited liability company are requested to present them in accordance with the Notice of Winding Up. You must furnish your name, address and telephone number together with the following: (i) Amount of the claim; (ii) Basis for the claim; and (iii) Documentation of the claim.

Claims must be mailed to: Jayne D. Corley, The Corley Law Firm, P.C., 999 Executive Parkway Drive, Suite 104, St. Louis, Missouri 63141.

A claim against the limited liability company will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the publication of this notice.

**NOTICE OF WINDING UP OF LIMITED PARTNERSHIP TO ALL
CREDITORS OF AND CLAIMANTS AGAINST WIL-MAR ACRES, LP**

On October 16, 2018, WIL-MAR ACRES, LP, a Missouri limited partnership, filed a Cancellation of Registration with the Missouri Secretary of State.

Persons with claims against the limited partnership are requested to present them in accordance with the Notice of Winding Up. You must furnish your name, address, and telephone number together with the following: (1) Amount of the claim; (2) Basis for the claim; and (3) Documentation of the claim.

Claims must be mailed to: Robert C. Black, 245 Main St., P.O. Box 2058, Platte City, MO 64079.

A claim against the limited partnership will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the publication of this notice.

**NOTICE OF DISSOLUTION TO ALL
CREDITORS AND CLAIMANTS AGAINST
BACK FORTY BISON, LLC**

BACK FORTY BISON, LLC (the "Company"), a Missouri limited liability company, was dissolved on January 8, 2018. Any and all claims against the Company should be forwarded to W. Bradley Risby, Neale & Newman, L.L.P., 1949 East Sunshine, Suite 1-130, Springfield, Missouri 65804. Each claim should include the following: (i) the name, address and telephone number of the claimant; (ii) the amount of the claim; (iii) the basis for the claim; and (iv) the date(s) on which the event(s) on which the claim is based occurred. Claims against the Company will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the publication of this notice.

**NOTICE OF WINDING UP TO CREDITORS OF AND CLAIMANTS
AGAINST J & J WALLER PROPERTIES, LLC**

J & J Waller Properties, LLC, a Missouri limited liability, filed its notice of winding up with the Missouri Secretary of State on October 17, 2018. If you believe you have a claim against the company, you must submit a written claim to Blanton, Nickell, Collins, Douglas & Hanschen LLC, c/o Bryan E. Nickell, PO Box 805, Sikeston, Missouri 63801. Claims must include: (1) the name, address, and telephone number of the claimant; (2) the amount claimed; (3) the basis of the claim; (4) the date on which the claim arose; and (5) any documentation in support of the claim. All claims against J & J Waller Properties, LLC will be barred unless a proceeding to enforce the claim is commenced within three years after the date of the publication of this notice.

**NOTICE OF DISSOLUTION OF LIMITED LIABILITY COMPANY
TO ALL CREDITORS OF AND CLAIMANTS AGAINST
MSJS FREEDOM, LLC**

On October 17, 2018, MSJS FREEDOM, LLC, a Missouri limited liability company (hereinafter the "Company"), filed its Notice of Winding Up with the Missouri Secretary of State and filed a Statement of Correction to the Notice of Winding Up on October 24, 2018.

The Company requests that all persons and organizations who have claims against it present them immediately by letter to: Jennifer J. Stanfield, 14209 Denver Road, Grandview, Missouri 64030. All claims must include the following information: name, address and phone number of the claimant; amount claimed; date on which the claim arose; basis for the claim; and any documentation in support of the claim.

ALL CLAIMS AGAINST THE COMPANY WILL BE BARRED UNLESS A PROCEEDING TO ENFORCE THE CLAIM IS COMMENCED WITHIN THREE (3) YEARS AFTER COMPLETION OF THREE PUBLICATIONS OF THIS NOTICE PURSUANT TO THE REVISED STATUTES OF MISSOURI, WHICHEVER IS PUBLISHED LAST.

**NOTICE OF WINDING UP AND DISSOLUTION OF LIMITED LIABILITY
COMPANY TO ALL CREDITORS OF AND CLAIMANTS AGAINST
KINION PROPERTIES LLC**

On October 25, 2018, Kinion Properties LLC, a Missouri limited liability company (the "Company"), filed its Notice of Winding Up and Articles of Termination of the Company with the Missouri Secretary of State to be effective December 31, 2018. The Company requests that all persons and organizations who have claims against the Company present them immediately by letter to Nicholas M. Burkemper, Attorney, c/o Summers Compton Wells LLC, 8909 Ladue Road, St. Louis, MO 63124. All claims must include the name and address of the claimant, the amount claimed, the basis for and a description of the claim, and include copies of any supporting documentation. Any and all claims against the Company will be barred unless a proceeding to enforce such claim is commenced within three (3) years after the publication of this notice.

**NOTICE OF DISSOLUTION
TO ALL CREDITORS OF
AND CLAIMANTS AGAINST
MVM THE EXCHANGE FUND, INC.**

MVM THE EXCHANGE FUND, INC., a Missouri corporation, filed its Articles of Dissolution by Voluntary Action with the Missouri Secretary of State on August 27, 2018. Any and all claims against MVM THE EXCHANGE FUND, INC. may be sent to Jonathan Goldstein, Advantage Capital, 190 Carondelet Plaza, Suite 1500, St. Louis, MO 63105. Each claim should include the following information: the name, address and telephone number of the claimant; the amount of the claim; the basis of the claim and the date(s) on which the event(s) on which the claim is based occurred.

Any and all claims against MVM THE EXCHANGE FUND, INC. will be barred unless a proceeding to enforce such claim is commenced within two (2) years after the date of this notice is published.

**NOTICE OF DISSOLUTION
TO ALL CREDITORS OF
AND CLAIMANTS AGAINST
MVM RIVERSTOCK FUND, INC.**

MVM RIVERSTOCK FUND, INC., a Missouri corporation, filed its Articles of Dissolution by Voluntary Action with the Missouri Secretary of State on August 27, 2018. Any and all claims against MVM RIVERSTOCK FUND, INC. may be sent to Jonathan Goldstein, Advantage Capital, 190 Carondelet Plaza, Suite 1500, St. Louis, MO 63105. Each claim should include the following information: the name, address and telephone number of the claimant; the amount of the claim; the basis of the claim and the date(s) on which the event(s) on which the claim is based occurred.

Any and all claims against MVM RIVERSTOCK, INC. will be barred unless a proceeding to enforce such claim is commenced within two (2) years after the date of this notice is published.

Notice of Dissolution of Corporation to All Creditors of And Claimants Against Henry Kraft Mercantile Company

On October 24, 2018, Henry Kraft Mercantile Company (the "Company") filed Articles of Dissolution with the Missouri Secretary of State. Claims against the Company may be mailed to Sally J. Sandy c/o Meredith P. Murphy, SmithAmundsen LLC, 120 S. Central Ave., Ste. 700, St. Louis, MO 63105. All claims must be presented in writing and must contain (a) the name and address of the claimant, (b) the amount claimed, (c) the basis for the claim, (d) the date(s) on which the event(s) on which the claim is based occurred, and (e) any documentation of the claim.

NOTICE: Because of the dissolution of Henry Kraft Mercantile Company, any claims against it will be barred unless a proceeding to enforce the claim is commenced within two (2) years after the public date of the notices authorized by statute, whichever is published last.

**NOTICE OF CORPORATE DISSOLUTION TO ALL
CREDITORS OF AND CLAIMANTS AGAINST
PARK HILLS PUBLIC SAFETY CORPORATION**

On October 9, 2018, Park Hills Public Safety Corporation, a Missouri Nonprofit Corporation, filed its Articles of Dissolution with the Missouri Secretary of State. The dissolution was effective on October 9, 2018.

You are hereby notified that if you believe you have a claim against Park Hills Public Safety Corporation, you must submit a summary in writing of the circumstances surrounding your claim to the corporation c/o Attorney Edward M. Pultz, PO Box 992, Farmington, MO 63640.

The summary of your claim must include the following information:

1. The name, address and telephone number of the claimant;
2. The amount of the claim;
3. The date on which the event on which the claim is based occurred;
4. A brief description of the nature of the debt or the basis for the claim.

All claims against Park Hills Public Safety Corporation will be barred unless the proceeding to enforce the claim is commenced within two years after the publication of this notice.

**NOTICE OF DISSOLUTION
To All Creditors and Claimants Against
TML-MFG, LLC
a Missouri Limited Liability Company**

On October 4, 2018, TML-MFG, LLC, a Missouri limited liability company, filed its Notice of Winding Up for Limited Liability Company with the Missouri Secretary of State. The effective date of the Company's dissolution and commencement of winding up of its business was that date.

TML-MFG, LLC requests that all persons who have claims against the Company present them immediately by letter to TML-MFG, LLC, 687 Trade Center Blvd., Suite 100, Chesterfield, MO 63005.

All claims must include the following: the name and address of the claimant; the amount claimed; the basis of the claim; and documentation of the claim.

Pursuant to Section 347.141 of the Revised Statutes of Missouri, as amended, any claim against TML-MFG, LLC will be barred unless a proceeding to enforce the claim is commenced within three years after the last publication of this notice.

NOTICE OF WINDING UP OF LIMITED LIABILITY COMPANY
TO ALL CREDITORS AND CLAIMANTS AGAINST
ABLES MANOR PROPERTIES LLC

On October 30, 2018, Ables Manor Properties LLC, a Missouri limited liability company (hereinafter the "Company"), filed its Notice of Winding Up for a Limited Liability Company with the Missouri Secretary of State.

Any claims against the Company may be sent to: **Terry Cole, 1311 Columbine, Sikeston, Missouri 63801**. Each claim must include the following information: name, address and phone number of the claimant; amount claimed; date on which the claim arose; the basis for the claim; and documentation in support of the claim.

All claims against the Company will be barred unless the proceeding to enforce the claim is commenced within three years after the publication of this notice.

"NOTICE OF DISSOLUTION

TO ALL CREDITORS AND CLAIMANTS AGAINST Monett Constructors, Inc., a Missouri Corporation (the "Corporation"):

You are hereby notified that dissolution of the Corporation was authorized by the shareholders on October 18, 2018. All persons having claims against the Corporation must present their claims in writing and mail their claims to:

Judy Brunner
5696 S. Nettleton
Springfield, MO 65810

A claim against the Corporation will be barred unless a proceeding to enforce the claim is commenced within two (2) years after the publication of this Notice. In order to file a claim with the Corporation, you must furnish the following: (a) the name, address and telephone number of the claimant; (b) the amount claimed; (c) a description of the nature of the debt or the basis of the claim; (d) the date or dates the claim accrued; and (e) if the claim is founded on a writing, a copy of the writing."

**NOTICE OF DISSOLUTION TO ALL CREDITORS OF AND
CLAIMANTS AGAINST WESTERN WAREHOUSING CORPORATION**

On October 29, 2018, Western Warehousing Corporation filed its Articles of Dissolution with the Missouri Secretary of State. The dissolution was effective on October 30, 2018.

You are hereby notified that if you believe you have a claim against Western Warehousing Corporation, you must submit a summary in writing of the circumstances surrounding your claim to the corporation at 1619 W. Evanston Ave., Tulsa, OK 74104. The summary of your claim must include the following information:

1. The name, address and telephone number of the claimant.
2. The amount of the claim.
3. The date on which the event on which the claim is based occurred.
4. A brief description of the nature of the debt or the basis for the claim.

All claims against Western Warehousing Corporation will be barred unless the proceeding to enforce the claim is commenced within two years after the publication of this notice.

Rule Changes Since Update to Code of State Regulations

This cumulative table gives you the latest status of rules. It contains citations of rulemakings adopted or proposed after deadline for the monthly Update Service to the *Code of State Regulations*, citations are to volume and page number in the *Missouri Register*, except for material in this issue. The first number in the table cite refers to the volume number or the publication year—42 (2017) and 43 (2018). MoReg refers to *Missouri Register* and the numbers refer to a specific *Register* page, R indicates a rescission, W indicates a withdrawal, S indicates a statement of actual cost, T indicates an order terminating a rule, N.A. indicates not applicable, RAN indicates a rule action notice, RUC indicates a rule under consideration, and F indicates future effective date.

Rule Number	Agency	Emergency	Proposed	Order	In Addition
1 CSR 10	OFFICE OF ADMINISTRATION State Officials' Salary Compensation Schedule				42 MoReg 1849 This Issue
1 CSR 10-3.010	Commissioner of Administration		43 MoReg 3205		
1 CSR 10-4.010	Commissioner of Administration		43 MoReg 3208R		
1 CSR 10-5.010	Commissioner of Administration		43 MoReg 3208		
1 CSR 10-7.010	Commissioner of Administration		43 MoReg 3209		
1 CSR 10-8.010	Commissioner of Administration		43 MoReg 3210		
1 CSR 10-9.010	Commissioner of Administration		43 MoReg 3210R		
1 CSR 10-11.010	Commissioner of Administration		43 MoReg 3211		
1 CSR 10-11.020	Commissioner of Administration		43 MoReg 3214R		
1 CSR 10-11.030	Commissioner of Administration		43 MoReg 3214R		
1 CSR 10-13.010	Commissioner of Administration		43 MoReg 3214R		
1 CSR 10-16.010	Commissioner of Administration		43 MoReg 3215		
1 CSR 10-18.010	Commissioner of Administration		43 MoReg 2975R		
1 CSR 20-1.010	Personnel Advisory Board and Division of Personnel	43 MoReg 2735	43 MoReg 2782		
1 CSR 20-1.020	Personnel Advisory Board and Division of Personnel	43 MoReg 2736	43 MoReg 2783		
1 CSR 20-1.030	Personnel Advisory Board and Division of Personnel		43 MoReg 2787R		
1 CSR 20-1.040	Personnel Advisory Board and Division of Personnel	43 MoReg 2740	43 MoReg 2787		
1 CSR 20-1.045	Personnel Advisory Board and Division of Personnel	43 MoReg 2741	43 MoReg 2788		
1 CSR 20-1.050	Personnel Advisory Board and Division of Personnel		43 MoReg 2790R		
1 CSR 20-2.010	Personnel Advisory Board and Division of Personnel	43 MoReg 2742	43 MoReg 2790		
1 CSR 20-2.015	Personnel Advisory Board and Division of Personnel	43 MoReg 2744	43 MoReg 2791		
1 CSR 20-2.020	Personnel Advisory Board and Division of Personnel	43 MoReg 2747	43 MoReg 2795		
1 CSR 20-3.010	Personnel Advisory Board and Division of Personnel	43 MoReg 2749	43 MoReg 2797		
1 CSR 20-3.020	Personnel Advisory Board and Division of Personnel	43 MoReg 2753	43 MoReg 2800		
1 CSR 20-3.030	Personnel Advisory Board and Division of Personnel	43 MoReg 2754	43 MoReg 2802		
1 CSR 20-3.040	Personnel Advisory Board and Division of Personnel	43 MoReg 2757	43 MoReg 2805		
1 CSR 20-3.050	Personnel Advisory Board and Division of Personnel	43 MoReg 2758R	43 MoReg 2806R		
1 CSR 20-3.070	Personnel Advisory Board and Division of Personnel	43 MoReg 2759	43 MoReg 2806		
1 CSR 20-3.080	Personnel Advisory Board and Division of Personnel	43 MoReg 2763	43 MoReg 2810		
1 CSR 20-4.010	Personnel Advisory Board and Division of Personnel	43 MoReg 2764R	43 MoReg 2811R		
1 CSR 20-4.020	Personnel Advisory Board and Division of Personnel	43 MoReg 2764	43 MoReg 2811		
1 CSR 30-2.020	Division of Facilities Management, Design and Construction		43 MoReg 2813R		
1 CSR 30-2.030	Division of Facilities Management, Design and Construction		43 MoReg 2813R		
1 CSR 30-2.040	Division of Facilities Management, Design and Construction		43 MoReg 2813R		
1 CSR 30-2.050	Division of Facilities Management, Design and Construction		43 MoReg 2814R		
1 CSR 30-3.010	Division of Facilities Management, Design and Construction		43 MoReg 2814R		
1 CSR 30-3.020	Division of Facilities Management, Design and Construction		43 MoReg 2814R		
1 CSR 30-3.030	Division of Facilities Management, Design and Construction		43 MoReg 3215		
1 CSR 30-3.035	Division of Facilities Management, Design and Construction		43 MoReg 2814R		
1 CSR 30-3.040	Division of Facilities Management, Design and Construction		43 MoReg 3218		
1 CSR 30-3.050	Division of Facilities Management, Design and Construction		43 MoReg 3221		
1 CSR 30-4.010	Division of Facilities Management, Design and Construction		43 MoReg 2815R		
1 CSR 35-1.050	Division of Facilities Management		43 MoReg 3222		
1 CSR 40-1.010	Purchasing and Materials Management		43 MoReg 3226R		
1 CSR 40-1.030	Purchasing and Materials Management		43 MoReg 3227R		
1 CSR 40-1.040	Purchasing and Materials Management		43 MoReg 3227R		
1 CSR 40-1.050	Purchasing and Materials Management	43 MoReg 2967	43 MoReg 3227		
1 CSR 40-1.090	Purchasing and Materials Management		43 MoReg 3237R		

Rule Number	Agency	Emergency	Proposed	Order	In Addition
DEPARTMENT OF AGRICULTURE					
2 CSR 10-1.010	Ag Business Development		43 MoReg 1258	43 MoReg 3114	
2 CSR 20-1.010	Administrative Services		43 MoReg 1417R	43 MoReg 3114R	
2 CSR 20-3.010	Administrative Services (<i>Changed to 2 CSR 110-4.010</i>)		43 MoReg 1417	43 MoReg 3116	
2 CSR 20-3.020	Administrative Services (<i>Changed to 2 CSR 110-4.020</i>)		43 MoReg 1418	43 MoReg 3117	
2 CSR 20-3.030	Administrative Services (<i>Changed to 2 CSR 110-4.030</i>)		43 MoReg 1418	43 MoReg 3117	
2 CSR 20-3.040	Administrative Services (<i>Changed to 2 CSR 110-4.040</i>)		43 MoReg 1418	43 MoReg 3117	
2 CSR 20-3.050	Administrative Services		43 MoReg 1419R	43 MoReg 3114R	
2 CSR 50-1.010	Fairs		43 MoReg 1258R	43 MoReg 3114R	
2 CSR 50-2.010	Fairs		43 MoReg 1259R	43 MoReg 3115R	
2 CSR 50-3.020	Fairs		43 MoReg 1259R	43 MoReg 3115R	
2 CSR 50-4.010	Fairs		43 MoReg 1259R	43 MoReg 3115R	
2 CSR 50-5.010	Fairs		43 MoReg 1259R	43 MoReg 3115R	
2 CSR 50-6.010	Fairs		43 MoReg 1260R	43 MoReg 3115R	
2 CSR 50-6.020	Fairs		43 MoReg 1260R	43 MoReg 3115R	
2 CSR 50-6.030	Fairs		43 MoReg 1260R	43 MoReg 3116R	
2 CSR 50-6.040	Fairs		43 MoReg 1260R	43 MoReg 3116R	
2 CSR 50-7.010	Fairs		43 MoReg 1261R	43 MoReg 3116R	
2 CSR 60-1.010	Grain Inspection and Warehousing		43 MoReg 1419	This Issue	
2 CSR 60-2.010	Grain Inspection and Warehousing		43 MoReg 1420R	This IssueR	
2 CSR 60-4.016	Grain Inspection and Warehousing		43 MoReg 1420R	This IssueR	
2 CSR 60-4.045	Grain Inspection and Warehousing		43 MoReg 1420R	This IssueR	
2 CSR 60-4.060	Grain Inspection and Warehousing		43 MoReg 1420R	This IssueR	
2 CSR 60-4.070	Grain Inspection and Warehousing		43 MoReg 1421R	This IssueR	
2 CSR 60-4.080	Grain Inspection and Warehousing		43 MoReg 1421	This Issue	
2 CSR 60-4.090	Grain Inspection and Warehousing		43 MoReg 1421R	This IssueR	
2 CSR 60-4.120	Grain Inspection and Warehousing		43 MoReg 1422	This Issue	
2 CSR 60-4.130	Grain Inspection and Warehousing		43 MoReg 1422	This Issue	
2 CSR 60-4.170	Grain Inspection and Warehousing		43 MoReg 1422	This Issue	
2 CSR 60-5.040	Grain Inspection and Warehousing		43 MoReg 1422R	This IssueR	
2 CSR 70-1.010	Plant Industries		43 MoReg 1549		
2 CSR 70-10.080	Plant Industries		43 MoReg 1550		
2 CSR 70-11.020	Plant Industries		43 MoReg 1554R		
2 CSR 70-11.030	Plant Industries		43 MoReg 1554R		
2 CSR 70-11.050	Plant Industries		43 MoReg 1555R		
2 CSR 70-12.010	Plant Industries		43 MoReg 1555R		
2 CSR 70-15.035	Plant Industries		43 MoReg 1555R		
2 CSR 70-15.045	Plant Industries		43 MoReg 1555		
2 CSR 70-16.010	Plant Industries		43 MoReg 1556R		
2 CSR 70-16.015	Plant Industries		43 MoReg 1556R		
2 CSR 70-16.020	Plant Industries		43 MoReg 1556R		
2 CSR 70-16.025	Plant Industries		43 MoReg 1556R		
2 CSR 70-16.030	Plant Industries		43 MoReg 1557R		
2 CSR 70-16.035	Plant Industries		43 MoReg 1557R		
2 CSR 70-16.040	Plant Industries		43 MoReg 1557R		
2 CSR 70-16.045	Plant Industries		43 MoReg 1558R		
2 CSR 70-16.050	Plant Industries		43 MoReg 1558R		
2 CSR 70-16.055	Plant Industries		43 MoReg 1558R		
2 CSR 70-16.060	Plant Industries		43 MoReg 1558R		
2 CSR 70-16.065	Plant Industries		43 MoReg 1559R		
2 CSR 70-16.070	Plant Industries		43 MoReg 1559R		
2 CSR 70-16.075	Plant Industries		43 MoReg 1559R		
2 CSR 70-25.070	Plant Industries		43 MoReg 1559R		
2 CSR 70-35.010	Plant Industries		43 MoReg 1560		
2 CSR 70-35.031	Plant Industries		43 MoReg 1560R		
2 CSR 70-40.005	Plant Industries		43 MoReg 1560R		
2 CSR 70-40.015	Plant Industries		43 MoReg 1561R		
2 CSR 70-40.016	Plant Industries		43 MoReg 1561R		
2 CSR 70-40.017	Plant Industries		43 MoReg 1561R		
2 CSR 70-40.025	Plant Industries		43 MoReg 1561R		
2 CSR 70-40.040	Plant Industries		43 MoReg 1562R		
2 CSR 70-40.050	Plant Industries		43 MoReg 1562R		
2 CSR 70-40.055	Plant Industries		43 MoReg 1562R		
2 CSR 80-2.001	State Milk Board (<i>Changed from 2 CSR 80-2.180</i>)		43 MoReg 1136	43 MoReg 2898	
2 CSR 80-2.002	State Milk Board (<i>Changed from 2 CSR 80-2.181</i>)		43 MoReg 1137	43 MoReg 2898	
2 CSR 80-2.003	State Milk Board		43 MoReg 1126	43 MoReg 2898	
2 CSR 80-2.010	State Milk Board		43 MoReg 1126R	43 MoReg 2898R	
2 CSR 80-2.020	State Milk Board		43 MoReg 1127	43 MoReg 2899	
2 CSR 80-2.030	State Milk Board		43 MoReg 1127	43 MoReg 2899	
2 CSR 80-2.040	State Milk Board		43 MoReg 1128R	43 MoReg 2899R	
2 CSR 80-2.050	State Milk Board		43 MoReg 1128R	43 MoReg 2899R	
2 CSR 80-2.060	State Milk Board		43 MoReg 1128R	43 MoReg 2899R	
2 CSR 80-2.070	State Milk Board		43 MoReg 1128	43 MoReg 2899	
2 CSR 80-2.080	State Milk Board		43 MoReg 1133R	43 MoReg 2900R	
2 CSR 80-2.091	State Milk Board		43 MoReg 1134R	43 MoReg 2900R	
2 CSR 80-2.101	State Milk Board		43 MoReg 1134R	43 MoReg 2900R	
2 CSR 80-2.110	State Milk Board		43 MoReg 1134R	43 MoReg 2900R	
2 CSR 80-2.121	State Milk Board		43 MoReg 1135R	43 MoReg 2900R	
2 CSR 80-2.130	State Milk Board		43 MoReg 1135R	43 MoReg 2900R	
2 CSR 80-2.141	State Milk Board		43 MoReg 1135R	43 MoReg 2900R	
2 CSR 80-2.151	State Milk Board		43 MoReg 1135R	43 MoReg 2901R	
2 CSR 80-2.161	State Milk Board		43 MoReg 1136R	43 MoReg 2901R	
2 CSR 80-2.170	State Milk Board		43 MoReg 1136R	43 MoReg 2901R	
2 CSR 80-2.180	State Milk Board (<i>Changed to 2 CSR 80-2.001</i>)		43 MoReg 1136	43 MoReg 2898	

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2 CSR 80-2.181	State Milk Board (<i>Changed to 2 CSR 80-2.002</i>)		43 MoReg 1137	43 MoReg 2898	
2 CSR 80-2.190	State Milk Board		43 MoReg 1137	43 MoReg 2901	
2 CSR 80-3.010	State Milk Board		43 MoReg 1139	43 MoReg 2901	
2 CSR 80-3.060	State Milk Board		43 MoReg 1139	43 MoReg 2901	
2 CSR 80-3.120	State Milk Board		43 MoReg 1139	43 MoReg 2902	
2 CSR 80-3.130	State Milk Board		43 MoReg 1139R	43 MoReg 2902R	
2 CSR 80-4.010	State Milk Board		43 MoReg 1140	43 MoReg 2902	
2 CSR 80-5.010	State Milk Board		43 MoReg 1140	43 MoReg 2902	
2 CSR 80-6.011	State Milk Board		43 MoReg 1141	43 MoReg 2902	
2 CSR 80-6.021	State Milk Board		43 MoReg 1141	43 MoReg 2902	
2 CSR 80-6.041	State Milk Board		43 MoReg 1142	43 MoReg 2903	
2 CSR 90-10	Weights, Measures and Consumer Protection				42 MoReg 1203
2 CSR 90-10.016	Weights, Measures and Consumer Protection		43 MoReg 1998R		
2 CSR 90-11.010	Weights, Measures and Consumer Protection		43 MoReg 1998		
2 CSR 90-20.040	Weights, Measures and Consumer Protection		43 MoReg 1999		
2 CSR 90-21.010	Weights, Measures and Consumer Protection		43 MoReg 1999		
2 CSR 90-22.140	Weights, Measures and Consumer Protection		43 MoReg 2001		
2 CSR 90-23.010	Weights, Measures and Consumer Protection		43 MoReg 2001		
2 CSR 90-25.010	Weights, Measures and Consumer Protection		43 MoReg 2002		
2 CSR 90-30.040	Weights, Measures and Consumer Protection		43 MoReg 667	43 MoReg 1919	
2 CSR 90-30.050	Weights, Measures and Consumer Protection		43 MoReg 2002		
2 CSR 90-30.070	Weights, Measures and Consumer Protection		43 MoReg 2004		
2 CSR 90-30.080	Weights, Measures and Consumer Protection		43 MoReg 2005		
2 CSR 90-30.090	Weights, Measures and Consumer Protection		43 MoReg 2006		
2 CSR 90-30.100	Weights, Measures and Consumer Protection		43 MoReg 2006		
2 CSR 90-36.010	Weights, Measures and Consumer Protection		43 MoReg 2007		
2 CSR 90-38.010	Weights, Measures and Consumer Protection		43 MoReg 2012R		
2 CSR 90-38.020	Weights, Measures and Consumer Protection		43 MoReg 2012R		
2 CSR 90-38.030	Weights, Measures and Consumer Protection		43 MoReg 2012R		
2 CSR 90-38.040	Weights, Measures and Consumer Protection		43 MoReg 2013R		
2 CSR 90-38.050	Weights, Measures and Consumer Protection		43 MoReg 2013R		
2 CSR 100-2.010	Missouri Agricultural and Small Business Development Authority		43 MoReg 1563R		
2 CSR 100-2.020	Missouri Agricultural and Small Business Development Authority		43 MoReg 1563R		
2 CSR 100-2.030	Missouri Agricultural and Small Business Development Authority		43 MoReg 1563R		
2 CSR 100-2.040	Missouri Agricultural and Small Business Development Authority		43 MoReg 1563R		
2 CSR 100-2.050	Missouri Agricultural and Small Business Development Authority		43 MoReg 1564R		
2 CSR 100-3.010	Missouri Agricultural and Small Business Development Authority		43 MoReg 1564R		
2 CSR 100-3.020	Missouri Agricultural and Small Business Development Authority		43 MoReg 1564R		
2 CSR 100-3.030	Missouri Agricultural and Small Business Development Authority		43 MoReg 1564R		
2 CSR 100-3.040	Missouri Agricultural and Small Business Development Authority		43 MoReg 1565R		
2 CSR 100-3.050	Missouri Agricultural and Small Business Development Authority		43 MoReg 1565R		
2 CSR 100-4.010	Missouri Agricultural and Small Business Development Authority		43 MoReg 1565R		
2 CSR 100-4.020	Missouri Agricultural and Small Business Development Authority		43 MoReg 1565R		
2 CSR 100-4.030	Missouri Agricultural and Small Business Development Authority		43 MoReg 1566R		
2 CSR 100-4.040	Missouri Agricultural and Small Business Development Authority		43 MoReg 1566R		
2 CSR 100-4.050	Missouri Agricultural and Small Business Development Authority		43 MoReg 1566R		
2 CSR 100-10.010	Missouri Agricultural and Small Business Development Authority		43 MoReg 1566		
2 CSR 110-1.010	Office of the Director		43 MoReg 1423R	43 MoReg 3116R	
2 CSR 110-2.010	Office of the Director		43 MoReg 1423R	43 MoReg 3116R	
2 CSR 110-4.010	Office of the Director (<i>Changed from 2 CSR 20-3.010</i>)		43 MoReg 1417	43 MoReg 3116	
2 CSR 110-4.020	Office of the Director (<i>Changed from 2 CSR 20-3.020</i>)		43 MoReg 1418	43 MoReg 3117	
2 CSR 110-4.030	Office of the Director (<i>Changed from 2 CSR 20-3.030</i>)		43 MoReg 1418	43 MoReg 3117	
2 CSR 110-4.040	Office of the Director (<i>Changed from 2 CSR 20-3.040</i>)		43 MoReg 1418	43 MoReg 3117	
DEPARTMENT OF CONSERVATION					
3 CSR 10-1.010	Conservation Commission		43 MoReg 2815		
3 CSR 10-4.200	Conservation Commission		43 MoReg 2815		
3 CSR 10-5.205	Conservation Commission		43 MoReg 2816		
3 CSR 10-5.215	Conservation Commission		43 MoReg 2822		
3 CSR 10-5.222	Conservation Commission		43 MoReg 2824		
3 CSR 10-5.600	Conservation Commission		43 MoReg 2824		
3 CSR 10-5.605	Conservation Commission		43 MoReg 2824		
3 CSR 10-6.415	Conservation Commission		43 MoReg 2824		
3 CSR 10-7.405	Conservation Commission		43 MoReg 2825		
3 CSR 10-7.410	Conservation Commission		43 MoReg 2825		
3 CSR 10-7.431	Conservation Commission		43 MoReg 2825		
3 CSR 10-7.433	Conservation Commission		43 MoReg 2828		
3 CSR 10-7.434	Conservation Commission		43 MoReg 2828		
3 CSR 10-7.455	Conservation Commission		43 MoReg 2829		43 MoReg 93
3 CSR 10-7.600	Conservation Commission		43 MoReg 2829		
3 CSR 10-10.715	Conservation Commission		43 MoReg 2833		

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3 CSR 10-10.768	Conservation Commission		43 MoReg 2833		
3 CSR 10-11.115	Conservation Commission		43 MoReg 2833		
3 CSR 10-11.120	Conservation Commission		43 MoReg 2834		
3 CSR 10-11.125	Conservation Commission		43 MoReg 2835		
3 CSR 10-11.130	Conservation Commission		43 MoReg 2836		
3 CSR 10-11.135	Conservation Commission		43 MoReg 2837		
3 CSR 10-11.140	Conservation Commission		43 MoReg 2837		
3 CSR 10-11.145	Conservation Commission		43 MoReg 2838		
3 CSR 10-11.155	Conservation Commission		43 MoReg 2838		
3 CSR 10-11.160	Conservation Commission		43 MoReg 2838		
3 CSR 10-11.180	Conservation Commission		43 MoReg 2839		
3 CSR 10-11.184	Conservation Commission		43 MoReg 2845		
3 CSR 10-11.185	Conservation Commission		43 MoReg 2845		
3 CSR 10-11.186	Conservation Commission		43 MoReg 2849		
3 CSR 10-11.200	Conservation Commission		43 MoReg 2849		
3 CSR 10-11.205	Conservation Commission		43 MoReg 2850		
3 CSR 10-11.210	Conservation Commission		43 MoReg 2851		
3 CSR 10-11.215	Conservation Commission		43 MoReg 2852		
3 CSR 10-12.145	Conservation Commission		N.A.	43 MoReg 2903	
3 CSR 10-20.805	Conservation Commission		43 MoReg 2853		
DEPARTMENT OF ECONOMIC DEVELOPMENT					
4 CSR 80-1.010	Division of Economic Development Programs*		43 MoReg 3059R		
4 CSR 80-2.010	Division of Economic Development Programs*		43 MoReg 3059R		
4 CSR 80-2.020	Division of Economic Development Programs*		43 MoReg 3059R		
4 CSR 80-2.030	Division of Economic Development Programs*		43 MoReg 3060R		
4 CSR 80-5.010	Division of Economic Development Programs*		43 MoReg 3060		
4 CSR 80-5.020	Division of Economic Development Programs*		43 MoReg 3061R		
4 CSR 80-7.010	Division of Economic Development Programs*		43 MoReg 3061R		
4 CSR 80-7.020	Division of Economic Development Programs*		43 MoReg 3061R		
4 CSR 80-7.030	Division of Economic Development Programs*		43 MoReg 3061R		
4 CSR 80-7.040	Division of Economic Development Programs*		43 MoReg 3062R		
4 CSR 85-2.010	Division of Business and Community Services		43 MoReg 3062		
4 CSR 85-2.015	Division of Business and Community Services		43 MoReg 3062R		
4 CSR 85-2.020	Division of Business and Community Services		43 MoReg 3063		
4 CSR 85-2.030	Division of Business and Community Services		43 MoReg 3064		
4 CSR 85-2.040	Division of Business and Community Services		43 MoReg 3065R		
4 CSR 85-6.010	Division of Business and Community Services		43 MoReg 3065R		
4 CSR 85-7.010	Division of Business and Community Services		43 MoReg 3065R		
4 CSR 195-1.010	Division of Workforce Development		43 MoReg 3066		
4 CSR 195-2.010	Division of Workforce Development		43 MoReg 3066R		
4 CSR 195-2.020	Division of Workforce Development		43 MoReg 3066R		
4 CSR 195-2.030	Division of Workforce Development		43 MoReg 3067R		
4 CSR 195-3.010	Division of Workforce Development		43 MoReg 3067R		
4 CSR 195-3.020	Division of Workforce Development		43 MoReg 3067R		
4 CSR 195-4.010	Division of Workforce Development		43 MoReg 3067R		
4 CSR 195-5.010	Division of Workforce Development		43 MoReg 3068R		
4 CSR 195-5.020	Division of Workforce Development		43 MoReg 3068R		
4 CSR 195-5.030	Division of Workforce Development		43 MoReg 3068R		
4 CSR 240-3.105	Public Service Commission		43 MoReg 979R	43 MoReg 2993R	
4 CSR 240-3.110	Public Service Commission		43 MoReg 1567R		
4 CSR 240-3.115	Public Service Commission		43 MoReg 1567R		
4 CSR 240-3.120	Public Service Commission		43 MoReg 1567R		
4 CSR 240-3.125	Public Service Commission		43 MoReg 1568R		
4 CSR 240-3.161	Public Service Commission		43 MoReg 1423R		
4 CSR 240-3.165	Public Service Commission		43 MoReg 1568R		
4 CSR 240-3.210	Public Service Commission		43 MoReg 1569R		
4 CSR 240-3.215	Public Service Commission		43 MoReg 1569R		
4 CSR 240-3.220	Public Service Commission		43 MoReg 1569R		
4 CSR 240-3.225	Public Service Commission		43 MoReg 1570R		
4 CSR 240-3.245	Public Service Commission		43 MoReg 1570R		
4 CSR 240-3.270	Public Service Commission		43 MoReg 1571R		
4 CSR 240-3.280	Public Service Commission		43 MoReg 1571R		
4 CSR 240-3.290	Public Service Commission		43 MoReg 1571R		
4 CSR 240-3.295	Public Service Commission		43 MoReg 1572R		
4 CSR 240-3.310	Public Service Commission		43 MoReg 1572R		
4 CSR 240-3.315	Public Service Commission		43 MoReg 1572R		
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4 CSR 240-3.335	Public Service Commission		43 MoReg 1574R		
4 CSR 240-3.405	Public Service Commission		43 MoReg 1574R		
4 CSR 240-3.410	Public Service Commission		43 MoReg 1574R		
4 CSR 240-3.415	Public Service Commission		43 MoReg 1575R		
4 CSR 240-3.420	Public Service Commission		43 MoReg 1575R		
4 CSR 240-3.435	Public Service Commission		43 MoReg 1575R		
4 CSR 240-3.605	Public Service Commission		43 MoReg 1576R		
4 CSR 240-3.610	Public Service Commission		43 MoReg 1576R		
4 CSR 240-3.615	Public Service Commission		43 MoReg 1577R		
4 CSR 240-3.620	Public Service Commission		43 MoReg 1577R		
4 CSR 240-3.640	Public Service Commission		43 MoReg 1577R		
4 CSR 240-10.085	Public Service Commission		43 MoReg 1424		
4 CSR 240-10.095	Public Service Commission		43 MoReg 1425		
4 CSR 240-10.105	Public Service Commission		43 MoReg 1578		
4 CSR 240-10.115	Public Service Commission		43 MoReg 1578		
4 CSR 240-10.125	Public Service Commission		43 MoReg 1579		
4 CSR 240-10.135	Public Service Commission		43 MoReg 1579		
4 CSR 240-10.145	Public Service Commission		43 MoReg 1580		
4 CSR 240-20.045	Public Service Commission		43 MoReg 979	43 MoReg 2993	
4 CSR 240-20.090	Public Service Commission		43 MoReg 1426		
4 CSR 240-28.010	Public Service Commission		43 MoReg 981	43 MoReg 3279	
4 CSR 240-28.011	Public Service Commission		43 MoReg 982	43 MoReg 3279	

[illegible]

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4 CSR 340-2	Division of Energy				43 MoReg 15
4 CSR 340-6.010	Division of Energy		43 MoReg 1142	43 MoReg 3005	
DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION					
5 CSR 20-100.160	Division of Learning Services		43 MoReg 3068		
5 CSR 20-100.200	Division of Learning Services		43 MoReg 3070		
5 CSR 20-100.300	Division of Learning Services (<i>Changed from 5 CSR 20-600.120</i>)		This Issue		
5 CSR 20-100.310	Division of Learning Services (<i>Changed from 5 CSR 20-600.130</i>)		This Issue		
5 CSR 20-100.320	Division of Learning Services (<i>Changed from 5 CSR 20-600.140</i>)		This Issue		
5 CSR 20-300.140	Division of Learning Services		43 MoReg 252R 43 MoReg 2013R	This IssueR	
5 CSR 20-400.510	Division of Learning Services		43 MoReg 2014	This Issue	
5 CSR 20-400.520	Division of Learning Services		43 MoReg 2015	This Issue	
5 CSR 20-400.560	Division of Learning Services		43 MoReg 2016	This Issue	
5 CSR 20-400.640	Division of Learning Services		42 MoReg 1581 43 MoReg 2017	This Issue	
5 CSR 20-600.120	Division of Learning Services (<i>Changed to 5 CSR 20-100.300</i>)		This Issue		
5 CSR 20-600.130	Division of Learning Services (<i>Changed to 5 CSR 20-100.310</i>)		This Issue		
5 CSR 20-600.140	Division of Learning Services (<i>Changed to 5 CSR 20-100.320</i>)		This Issue		
5 CSR 30-345.030	Division of Financial and Administrative Services		43 MoReg 3071		
DEPARTMENT OF HIGHER EDUCATION					
6 CSR 10-2.070	Commissioner of Higher Education		43 MoReg 2020R	43 MoReg 3293R	
6 CSR 10-4.010	Commissioner of Higher Education		43 MoReg 123 This Issue		
6 CSR 10-8.010	Commissioner of Higher Education		43 MoReg 2020R	43 MoReg 3294R	
6 CSR 10-8.020	Commissioner of Higher Education		43 MoReg 2020R	43 MoReg 3294R	
MISSOURI DEPARTMENT OF TRANSPORTATION					
7 CSR	Department of Transportation				41 MoReg 845
7 CSR 10-11.010	Missouri Highways and Transportation Commission		43 MoReg 1261	43 MoReg 3294	
7 CSR 10-11.020	Missouri Highways and Transportation Commission		43 MoReg 1262	43 MoReg 3294	
7 CSR 10-11.030	Missouri Highways and Transportation Commission		43 MoReg 1265	43 MoReg 3294	
7 CSR 10-19.010	Missouri Highways and Transportation Commission		42 MoReg 93R		
7 CSR 10-20.010	Missouri Highways and Transportation Commission		43 MoReg 1014	43 MoReg 2903	
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS					
8 CSR	Department of Labor and Industrial Relations				41 MoReg 845
8 CSR 30-1.010	Division of Labor Standards		43 MoReg 2021		
8 CSR 30-2.010	Division of Labor Standards		43 MoReg 2021		
8 CSR 30-2.020	Division of Labor Standards		43 MoReg 2021		
8 CSR 30-3.010	Division of Labor Standards		43 MoReg 2028		
8 CSR 30-3.020	Division of Labor Standards		43 MoReg 2029		
8 CSR 30-3.030	Division of Labor Standards		43 MoReg 2030		
8 CSR 30-3.040	Division of Labor Standards		43 MoReg 2031		
8 CSR 30-3.050	Division of Labor Standards		43 MoReg 2031R		
8 CSR 30-3.060	Division of Labor Standards		43 MoReg 2031		
8 CSR 30-4.010	Division of Labor Standards		43 MoReg 2034		
8 CSR 30-4.020	Division of Labor Standards		43 MoReg 2035		
8 CSR 30-4.040	Division of Labor Standards		43 MoReg 2035		
8 CSR 30-4.050	Division of Labor Standards		43 MoReg 2035		
8 CSR 30-4.060	Division of Labor Standards		43 MoReg 2036		
8 CSR 30-5.010	Division of Labor Standards		43 MoReg 2037		
8 CSR 30-5.020	Division of Labor Standards		43 MoReg 2037		
8 CSR 30-5.030	Division of Labor Standards		43 MoReg 2038		
8 CSR 30-6.010	Division of Labor Standards		43 MoReg 2039		
8 CSR 60-1.010	Missouri Commission on Human Rights		43 MoReg 1143	43 MoReg 3005	
8 CSR 60-2.025	Missouri Commission on Human Rights		43 MoReg 1144	43 MoReg 3006	
8 CSR 60-2.045	Missouri Commission on Human Rights		43 MoReg 1144	43 MoReg 3006	
8 CSR 60-2.085	Missouri Commission on Human Rights		43 MoReg 1145R	43 MoReg 3006R	
8 CSR 60-2.090	Missouri Commission on Human Rights		43 MoReg 1145	43 MoReg 3006	
8 CSR 60-3.010	Missouri Commission on Human Rights		43 MoReg 1145	43 MoReg 3006	
8 CSR 60-3.030	Missouri Commission on Human Rights		43 MoReg 1146R	43 MoReg 3006R	
8 CSR 60-3.060	Missouri Commission on Human Rights		43 MoReg 1146	43 MoReg 3007	
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9 CSR	Department of Mental Health				41 MoReg 845
9 CSR 10-5.240	Director, Department of Mental Health (<i>Changed to 9 CSR 10-7.035</i>)		43 MoReg 2975		
9 CSR 10-7.035	Director, Department of Mental Health (<i>Changed from 9 CSR 10-5.240</i>)		43 MoReg 2975		
9 CSR 30-3.134	Certification Standards		43 MoReg 1147	43 MoReg 2903	
9 CSR 40-1.118	Licensing Rules		43 MoReg 837R	43 MoReg 2904R	
9 CSR 45-4.010	Division of Developmental Disabilities		43 MoReg 837R	43 MoReg 2904R	
9 CSR 45-5.105	Division of Developmental Disabilities		43 MoReg 838	43 MoReg 2904	
9 CSR 45-5.110	Division of Developmental Disabilities		43 MoReg 838	43 MoReg 2904	
9 CSR 45-5.130	Division of Developmental Disabilities		43 MoReg 842	43 MoReg 2904	
9 CSR 45-5.140	Division of Developmental Disabilities		43 MoReg 846	43 MoReg 2904	
9 CSR 45-5.150	Division of Developmental Disabilities		43 MoReg 850	43 MoReg 2905	
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10 CSR	Department of Natural Resources				41 MoReg 845
10 CSR 1-3.010	Director's Office		43 MoReg 2039		
10 CSR 10-1.010	Air Conservation Commission		43 MoReg 853	43 MoReg 2905	

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10 CSR 10-2.205	Air Conservation Commission		43 MoReg 2039		
10 CSR 10-2.215	Air Conservation Commission		43 MoReg 1015R	This IssueR	
10 CSR 10-2.230	Air Conservation Commission		43 MoReg 2042		
10 CSR 10-2.260	Air Conservation Commission		43 MoReg 1266		
10 CSR 10-2.300	Air Conservation Commission		43 MoReg 1270		
10 CSR 10-2.320	Air Conservation Commission		43 MoReg 1016	This Issue	
10 CSR 10-2.340	Air Conservation Commission		43 MoReg 1017	This Issue	
10 CSR 10-2.390	Air Conservation Commission		43 MoReg 1018R	This IssueR	
10 CSR 10-5.220	Air Conservation Commission		43 MoReg 2046		
10 CSR 10-5.295	Air Conservation Commission		43 MoReg 2052		
10 CSR 10-5.330	Air Conservation Commission		43 MoReg 2055		
10 CSR 10-5.360	Air Conservation Commission		43 MoReg 1019R	This IssueR	
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10 CSR 10-5.410	Air Conservation Commission		43 MoReg 1020R	This IssueR	
10 CSR 10-5.440	Air Conservation Commission		43 MoReg 1020R	This IssueR	
10 CSR 10-5.455	Air Conservation Commission		43 MoReg 1020R	This IssueR	
10 CSR 10-5.500	Air Conservation Commission		43 MoReg 1272		
10 CSR 10-5.520	Air Conservation Commission		43 MoReg 1021R	This IssueR	
10 CSR 10-5.530	Air Conservation Commission		43 MoReg 1277		
10 CSR 10-5.540	Air Conservation Commission		43 MoReg 1282		
10 CSR 10-5.570	Air Conservation Commission		43 MoReg 1021	This Issue	
10 CSR 10-6.030	Air Conservation Commission		43 MoReg 1024	This Issue	
10 CSR 10-6.040	Air Conservation Commission		43 MoReg 1026	This Issue	
10 CSR 10-6.045	Air Conservation Commission		43 MoReg 2073		
10 CSR 10-6.060	Air Conservation Commission		43 MoReg 2076		
10 CSR 10-6.062	Air Conservation Commission		43 MoReg 2101		
10 CSR 10-6.065	Air Conservation Commission		43 MoReg 2104		
10 CSR 10-6.070	Air Conservation Commission		43 MoReg 1287		
10 CSR 10-6.075	Air Conservation Commission		43 MoReg 1293		
10 CSR 10-6.080	Air Conservation Commission		43 MoReg 1301		
10 CSR 10-6.110	Air Conservation Commission		43 MoReg 1029	This Issue	
10 CSR 10-6.120	Air Conservation Commission		43 MoReg 1303		
10 CSR 10-6.130	Air Conservation Commission		43 MoReg 1304		
10 CSR 10-6.161	Air Conservation Commission		43 MoReg 1312		
10 CSR 10-6.170	Air Conservation Commission		43 MoReg 2126		
10 CSR 10-6.180	Air Conservation Commission		43 MoReg 855	43 MoReg 2905	
10 CSR 10-6.200	Air Conservation Commission		43 MoReg 1032	This Issue	
10 CSR 10-6.220	Air Conservation Commission		43 MoReg 2127		
10 CSR 10-6.241	Air Conservation Commission		43 MoReg 1313		
10 CSR 10-6.250	Air Conservation Commission		43 MoReg 1316		
10 CSR 10-6.261	Air Conservation Commission		43 MoReg 2129		
10 CSR 10-6.280	Air Conservation Commission		43 MoReg 1319		
10 CSR 10-6.300	Air Conservation Commission		43 MoReg 1320		
10 CSR 10-6.330	Air Conservation Commission		43 MoReg 2134		
10 CSR 10-6.362	Air Conservation Commission		43 MoReg 1046R	This IssueR	
10 CSR 10-6.364	Air Conservation Commission		43 MoReg 1047R	This IssueR	
10 CSR 10-6.366	Air Conservation Commission		43 MoReg 1047R	This IssueR	
10 CSR 10-6.372	Air Conservation Commission		43 MoReg 2137		
10 CSR 10-6.374	Air Conservation Commission		43 MoReg 2144		
10 CSR 10-6.376	Air Conservation Commission		43 MoReg 2151		
10 CSR 10-6.380	Air Conservation Commission		43 MoReg 1326		
10 CSR 10-6.390	Air Conservation Commission		43 MoReg 2158		
10 CSR 20-2.010	Clean Water Commission		43 MoReg 1148	This Issue	
10 CSR 20-4.010	Clean Water Commission		43 MoReg 1596R		
10 CSR 20-4.030	Clean Water Commission		43 MoReg 1596		
10 CSR 20-4.040	Clean Water Commission		43 MoReg 1598		
10 CSR 20-4.041	Clean Water Commission		43 MoReg 1609		
10 CSR 20-4.042	Clean Water Commission		43 MoReg 1611R		
10 CSR 20-4.050	Clean Water Commission		43 MoReg 1611		
10 CSR 20-4.061	Clean Water Commission		43 MoReg 1615		
10 CSR 20-6.010	Clean Water Commission		43 MoReg 1618		
10 CSR 20-6.011	Clean Water Commission		43 MoReg 1629		
10 CSR 20-6.015	Clean Water Commission		43 MoReg 1632		
10 CSR 20-6.020	Clean Water Commission		43 MoReg 1633		
10 CSR 20-6.070	Clean Water Commission		43 MoReg 1635		
10 CSR 20-6.090	Clean Water Commission		43 MoReg 1637		
10 CSR 20-6.200	Clean Water Commission		43 MoReg 1642		
10 CSR 20-6.300	Clean Water Commission		43 MoReg 1652		
10 CSR 20-7.015	Clean Water Commission		43 MoReg 1655		
10 CSR 20-8.020	Clean Water Commission		43 MoReg 1669R		
10 CSR 20-8.110	Clean Water Commission		43 MoReg 1669		
10 CSR 20-8.120	Clean Water Commission		43 MoReg 1680		
10 CSR 20-8.125	Clean Water Commission		43 MoReg 1685		
10 CSR 20-8.130	Clean Water Commission		43 MoReg 1687		
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10 CSR 20-8.500	Clean Water Commission		43 MoReg 1738		
10 CSR 20-9.010	Clean Water Commission		43 MoReg 1742		
10 CSR 20-9.020	Clean Water Commission		43 MoReg 1743		
10 CSR 20-9.030	Clean Water Commission		43 MoReg 1746		
10 CSR 20-14.010	Clean Water Commission		43 MoReg 1749		
10 CSR 20-14.020	Clean Water Commission		43 MoReg 1749		
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10 CSR 22-2.020	Dam and Reservoir Safety Council		43 MoReg 2162		
10 CSR 22-2.100	Dam and Reservoir Safety Council		43 MoReg 2163		
10 CSR 22-3.020	Dam and Reservoir Safety Council		43 MoReg 2163		
10 CSR 22-3.030	Dam and Reservoir Safety Council		43 MoReg 2165		
10 CSR 22-3.040	Dam and Reservoir Safety Council		43 MoReg 2166		
10 CSR 22-3.050	Dam and Reservoir Safety Council		43 MoReg 2169		
10 CSR 22-4.020	Dam and Reservoir Safety Council		43 MoReg 2170		
10 CSR 23-1.010	Well Installation		43 MoReg 2170		
10 CSR 23-1.030	Well Installation*		43 MoReg 2176R		
10 CSR 23-1.040	Well Installation		43 MoReg 2176		
10 CSR 23-1.050	Well Installation		43 MoReg 2177		
10 CSR 23-1.060	Well Installation*		43 MoReg 2181R		
10 CSR 23-1.075	Well Installation		43 MoReg 2181		
10 CSR 23-1.080	Well Installation*		43 MoReg 2183R		
10 CSR 23-1.090	Well Installation		43 MoReg 2183		
10 CSR 23-1.105	Well Installation		43 MoReg 2184		
10 CSR 23-1.130	Well Installation*		43 MoReg 2185R		
10 CSR 23-1.140	Well Installation		43 MoReg 2185		
10 CSR 23-1.155	Well Installation*		43 MoReg 2185R		
10 CSR 23-1.160	Well Installation		43 MoReg 2186		
10 CSR 23-2.010	Well Installation		43 MoReg 2186		
10 CSR 23-2.020	Well Installation		43 MoReg 2188		
10 CSR 23-3.010	Well Installation		43 MoReg 2188		
10 CSR 23-3.020	Well Installation		43 MoReg 2191		
10 CSR 23-3.030	Well Installation		43 MoReg 2192		
10 CSR 23-3.040	Well Installation*		43 MoReg 2203R		
10 CSR 23-3.050	Well Installation		43 MoReg 2203		
10 CSR 23-3.060	Well Installation*		43 MoReg 2213R		
10 CSR 23-3.070	Well Installation*		43 MoReg 2213R		
10 CSR 23-3.080	Well Installation		43 MoReg 2213		
10 CSR 23-3.090	Well Installation		43 MoReg 2218		
10 CSR 23-3.100	Well Installation*		43 MoReg 2246R		
10 CSR 23-3.110	Well Installation		43 MoReg 2246		
10 CSR 23-4.010	Well Installation*		43 MoReg 2250R		
10 CSR 23-4.020	Well Installation*		43 MoReg 2250R		
10 CSR 23-4.030	Well Installation*		43 MoReg 2250R		
10 CSR 23-4.050	Well Installation		43 MoReg 2250		
10 CSR 23-4.060	Well Installation		43 MoReg 2251		
10 CSR 23-4.080	Well Installation		43 MoReg 2255		
10 CSR 23-5.010	Well Installation*		43 MoReg 2256R		
10 CSR 23-5.020	Well Installation*		43 MoReg 2256R		
10 CSR 23-5.030	Well Installation		43 MoReg 2256		
10 CSR 23-5.040	Well Installation		43 MoReg 2256		
10 CSR 23-5.050	Well Installation		43 MoReg 2257		
10 CSR 23-5.060	Well Installation		43 MoReg 2259		
10 CSR 23-5.070	Well Installation		43 MoReg 1153R	43 MoReg 3127R	
10 CSR 23-5.080	Well Installation*		43 MoReg 2259		
10 CSR 23-6.010	Well Installation*		43 MoReg 2260R		
10 CSR 23-6.020	Well Installation		43 MoReg 2260		
10 CSR 23-6.030	Well Installation		43 MoReg 2261		
10 CSR 23-6.040	Well Installation		43 MoReg 2261		
10 CSR 23-6.050	Well Installation		43 MoReg 2261		
10 CSR 23-6.060	Well Installation*		43 MoReg 2263R		
10 CSR 24-1.010	Hazardous Substance Emergency Response Office		43 MoReg 856	43 MoReg 3127	
10 CSR 25-2.010	Hazardous Waste Management Commission		43 MoReg 1759		
10 CSR 25-2.020	Hazardous Waste Management Commission		43 MoReg 1759R		
10 CSR 25-3.260	Hazardous Waste Management Commission		43 MoReg 1759		
10 CSR 25-4.261	Hazardous Waste Management Commission		43 MoReg 1761		
10 CSR 25-5.262	Hazardous Waste Management Commission		43 MoReg 1765		
10 CSR 25-6.263	Hazardous Waste Management Commission		43 MoReg 1767		
10 CSR 25-7.264	Hazardous Waste Management Commission		43 MoReg 1772		
10 CSR 25-7.265	Hazardous Waste Management Commission		43 MoReg 1774		
10 CSR 25-7.266	Hazardous Waste Management Commission		43 MoReg 1777		
10 CSR 25-7.270	Hazardous Waste Management Commission		43 MoReg 1778		
10 CSR 25-8.124	Hazardous Waste Management Commission		43 MoReg 1779		
10 CSR 25-9.020	Hazardous Waste Management Commission		43 MoReg 1787R		
10 CSR 25-10.010	Hazardous Waste Management Commission		43 MoReg 1790R		
10 CSR 25-11.279	Hazardous Waste Management Commission		43 MoReg 1790		
10 CSR 25-12.010	Hazardous Waste Management Commission		43 MoReg 1792		
10 CSR 25-13.010	Hazardous Waste Management Commission		43 MoReg 1795		
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10 CSR 25-16.273	Hazardous Waste Management Commission		43 MoReg 1800		
10 CSR 25-19.010	Hazardous Waste Management Commission		43 MoReg 856	43 MoReg 3007	
10 CSR 26-1.010	Petroleum and Hazardous Substance Storage Tanks		43 MoReg 271R	43 MoReg 1938R	
10 CSR 26-2.080	Petroleum and Hazardous Substance Storage Tanks		43 MoReg 2263		
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10 CSR 40-3.170	Missouri Mining Commission		43 MoReg 862	43 MoReg 2906	
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10 CSR 40-3.220	Missouri Mining Commission		43 MoReg 864R	43 MoReg 2907R	
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10 CSR 40-3.240	Missouri Mining Commission		43 MoReg 864R	43 MoReg 2907R	
10 CSR 40-3.250	Missouri Mining Commission		43 MoReg 864R	43 MoReg 2907R	
10 CSR 40-3.260	Missouri Mining Commission		43 MoReg 865R	43 MoReg 2908R	
10 CSR 40-3.270	Missouri Mining Commission		43 MoReg 865R	43 MoReg 2908R	

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10 CSR 40-3.290	Missouri Mining Commission		43 MoReg 865R	43 MoReg 2908R	
10 CSR 40-3.300	Missouri Mining Commission		43 MoReg 866R	43 MoReg 2908R	
10 CSR 40-3.310	Missouri Mining Commission		43 MoReg 866R	43 MoReg 2909R	
10 CSR 40-4.020	Missouri Mining Commission		43 MoReg 866	43 MoReg 2909	
10 CSR 40-4.040	Missouri Mining Commission		43 MoReg 867	43 MoReg 2909	
10 CSR 40-4.060	Missouri Mining Commission		43 MoReg 868	43 MoReg 2909	
10 CSR 40-4.070	Missouri Mining Commission		43 MoReg 869	43 MoReg 2910	
10 CSR 40-6.100	Missouri Mining Commission		43 MoReg 870	43 MoReg 2910	
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10 CSR 40-9.010	Missouri Mining Commission		43 MoReg 873	43 MoReg 2911	
10 CSR 40-9.020	Missouri Mining Commission		43 MoReg 873	43 MoReg 2911	
10 CSR 40-9.030	Missouri Mining Commission		43 MoReg 874	43 MoReg 2911	
10 CSR 40-9.040	Missouri Mining Commission		43 MoReg 875	43 MoReg 2911	
10 CSR 40-9.050	Missouri Mining Commission		43 MoReg 876	43 MoReg 2912	
10 CSR 40-9.060	Missouri Mining Commission		43 MoReg 877	43 MoReg 2912	
10 CSR 40-10.010	Missouri Mining Commission		43 MoReg 877	43 MoReg 2912	
10 CSR 40-10.030	Missouri Mining Commission		43 MoReg 878	43 MoReg 2912	
10 CSR 40-10.040	Missouri Mining Commission		43 MoReg 879	43 MoReg 2912	
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10 CSR 45-6.020	Metallic Minerals Waste Management		43 MoReg 884	43 MoReg 3007	
10 CSR 45-8.010	Metallic Minerals Waste Management		43 MoReg 885	43 MoReg 3008	
10 CSR 45-8.030	Metallic Minerals Waste Management		43 MoReg 886	43 MoReg 3008	
10 CSR 45-8.040	Metallic Minerals Waste Management		43 MoReg 886	43 MoReg 3008	
10 CSR 50-1.020	Oil and Gas Council		43 MoReg 2265		
10 CSR 50-1.030	Oil and Gas Council		43 MoReg 2266		
10 CSR 50-1.050	Oil and Gas Council		43 MoReg 2268		
10 CSR 50-2.010	Oil and Gas Council		43 MoReg 2268		
10 CSR 50-2.020	Oil and Gas Council		43 MoReg 2269		
10 CSR 50-2.030	Oil and Gas Council		43 MoReg 2272		
10 CSR 50-2.040	Oil and Gas Council		43 MoReg 2273		
10 CSR 50-2.055	Oil and Gas Council		43 MoReg 2274		
10 CSR 50-2.060	Oil and Gas Council		43 MoReg 2276		
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10 CSR 60-2.015	Safe Drinking Water Commission		43 MoReg 1047	43 MoReg 3127	
10 CSR 60-3.010	Safe Drinking Water Commission		43 MoReg 1802		
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10 CSR 60-4.022	Safe Drinking Water Commission		43 MoReg 1805		
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10 CSR 60-4.094	Safe Drinking Water Commission		43 MoReg 1824		
10 CSR 60-4.100	Safe Drinking Water Commission		43 MoReg 1834		
10 CSR 60-6.050	Safe Drinking Water Commission		43 MoReg 1050R	43 MoReg 3128R	
10 CSR 60-6.060	Safe Drinking Water Commission		43 MoReg 1835		
10 CSR 60-6.070	Safe Drinking Water Commission		43 MoReg 1836		
10 CSR 60-7.010	Safe Drinking Water Commission		43 MoReg 1837		
10 CSR 60-8.010	Safe Drinking Water Commission		43 MoReg 1843		
10 CSR 60-8.030	Safe Drinking Water Commission		43 MoReg 1848		
10 CSR 60-9.010	Safe Drinking Water Commission		43 MoReg 1860		
10 CSR 60-10.010	Safe Drinking Water Commission		43 MoReg 1050	43 MoReg 3128	
10 CSR 60-11.010	Safe Drinking Water Commission		43 MoReg 1860		
10 CSR 60-11.030	Safe Drinking Water Commission		43 MoReg 1861		
10 CSR 60-13.010	Safe Drinking Water Commission		43 MoReg 1861		
10 CSR 60-13.020	Safe Drinking Water Commission		43 MoReg 1863		
10 CSR 60-13.025	Safe Drinking Water Commission		43 MoReg 1875		
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10 CSR 60-16.010	Safe Drinking Water Commission		43 MoReg 1051	43 MoReg 3129	
10 CSR 60-16.020	Safe Drinking Water Commission		43 MoReg 1053	43 MoReg 3129	
10 CSR 60-16.030	Safe Drinking Water Commission		43 MoReg 1053	43 MoReg 3129	
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10 CSR 70-3.010	Soil and Water Districts Commission		43 MoReg 1439	This Issue	
10 CSR 70-4.010	Soil and Water Districts Commission		43 MoReg 1441	This Issue	
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10 CSR 80-4.010	Solid Waste Management		43 MoReg 2307R		
10 CSR 80-6.010	Solid Waste Management		43 MoReg 1892R		
10 CSR 80-7.010	Solid Waste Management		43 MoReg 1893		
10 CSR 80-8.020	Solid Waste Management		43 MoReg 1895		
10 CSR 80-8.030	Solid Waste Management		43 MoReg 1896		
10 CSR 80-8.050	Solid Waste Management		43 MoReg 1897		
10 CSR 80-9.030	Solid Waste Management		43 MoReg 1054		

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10 CSR 90-2.030	State Parks		43 MoReg 1908		
10 CSR 90-2.040	State Parks		43 MoReg 1912		
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10 CSR 90-2.070	State Parks		43 MoReg 1914		
10 CSR 90-3.010	State Parks		43 MoReg 887	43 MoReg 3008	
10 CSR 90-3.020	State Parks		43 MoReg 887	43 MoReg 3008	
10 CSR 90-3.030	State Parks		43 MoReg 888	43 MoReg 3009	
10 CSR 130-1.010	State Environmental Improvement and Energy Resources Authority		43 MoReg 2308	This IssueW	
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10 CSR 130-1.020	State Environmental Improvement and Energy Resources Authority		43 MoReg 2309	This IssueW	
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11 CSR	Department of Public Safety				42 MoReg 990
11 CSR 30-8.010	Office of the Director		43 MoReg 1328R		
11 CSR 30-8.020	Office of the Director		43 MoReg 1328R		
11 CSR 30-8.030	Office of the Director		43 MoReg 1328R		
11 CSR 30-8.040	Office of the Director		43 MoReg 1328R		
11 CSR 30-9.010	Office of the Director		43 MoReg 1329R		
11 CSR 30-9.020	Office of the Director		43 MoReg 1329R		
11 CSR 30-9.030	Office of the Director		43 MoReg 1329R		
11 CSR 30-9.040	Office of the Director		43 MoReg 1329R		
11 CSR 30-9.050	Office of the Director		43 MoReg 1330R		
11 CSR 30-16.010	Office of the Director		42 MoReg 180		
11 CSR 30-16.020	Office of the Director		42 MoReg 182		
11 CSR 45-1.015	Missouri Gaming Commission		43 MoReg 1153	43 MoReg 3294	
11 CSR 45-1.090	Missouri Gaming Commission		43 MoReg 1155	43 MoReg 3295	
11 CSR 45-4.020	Missouri Gaming Commission		43 MoReg 1156	43 MoReg 3295	
11 CSR 45-4.210	Missouri Gaming Commission		43 MoReg 1157	43 MoReg 3295	
11 CSR 45-4.260	Missouri Gaming Commission		43 MoReg 1157	43 MoReg 3295	
11 CSR 45-4.380	Missouri Gaming Commission		43 MoReg 1158	43 MoReg 3295	
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11 CSR 45-5.065	Missouri Gaming Commission		43 MoReg 1158	43 MoReg 3296	
11 CSR 45-5.181	Missouri Gaming Commission		43 MoReg 1158	43 MoReg 3296	
11 CSR 45-5.184	Missouri Gaming Commission		43 MoReg 1159	43 MoReg 3296	
11 CSR 45-5.260	Missouri Gaming Commission		43 MoReg 1159	43 MoReg 3296	
11 CSR 45-6.010	Missouri Gaming Commission		43 MoReg 1160	43 MoReg 3296	
11 CSR 45-6.020	Missouri Gaming Commission		43 MoReg 1160	43 MoReg 3296	
11 CSR 45-6.025	Missouri Gaming Commission		43 MoReg 1162	43 MoReg 3297	
11 CSR 45-6.030	Missouri Gaming Commission		43 MoReg 1163	43 MoReg 3297	
11 CSR 45-7.090	Missouri Gaming Commission		43 MoReg 1448R	This IssueR	
11 CSR 45-7.130	Missouri Gaming Commission		This Issue		
11 CSR 45-7.160	Missouri Gaming Commission		43 MoReg 1163	43 MoReg 3297	
11 CSR 45-8.050	Missouri Gaming Commission		43 MoReg 1164	43 MoReg 3297	
11 CSR 45-8.060	Missouri Gaming Commission		43 MoReg 1164	43 MoReg 3297	
11 CSR 45-8.090	Missouri Gaming Commission		43 MoReg 1165	43 MoReg 3298	
11 CSR 45-8.130	Missouri Gaming Commission		43 MoReg 1165	43 MoReg 3298	
11 CSR 45-8.150	Missouri Gaming Commission		43 MoReg 1165	43 MoReg 3298	
11 CSR 45-9.101	Missouri Gaming Commission		43 MoReg 1166	43 MoReg 3298	
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11 CSR 45-9.106	Missouri Gaming Commission		This Issue		
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11 CSR 45-9.120	Missouri Gaming Commission		43 MoReg 1166	43 MoReg 3298	
11 CSR 45-10.020	Missouri Gaming Commission		43 MoReg 1449	This Issue	
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11 CSR 45-30.065	Missouri Gaming Commission		43 MoReg 1167	43 MoReg 3299	
11 CSR 45-30.480	Missouri Gaming Commission		43 MoReg 1167R	43 MoReg 3299R	
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11 CSR 45-30.555	Missouri Gaming Commission		43 MoReg 1167	43 MoReg 3299	
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11 CSR 45-40.060	Missouri Gaming Commission		43 MoReg 1449	This Issue	
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11 CSR 70-2.010	Division of Alcohol and Tobacco Control		43 MoReg 3241		
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11 CSR 70-2.270	Division of Alcohol and Tobacco Control		43 MoReg 3259		
11 CSR 70-2.280	Division of Alcohol and Tobacco Control		43 MoReg 3260		
11 CSR 70-3.010	Division of Alcohol and Tobacco Control		43 MoReg 3262		
11 CSR 70-3.020	Division of Alcohol and Tobacco Control		43 MoReg 2462R		
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12 CSR	Department of Revenue				42 MoReg 990
12 CSR 10-2.010	Director of Revenue		43 MoReg 3263		
12 CSR 10-3.017	Director of Revenue (<i>Changed to 12 CSR 10-103.017</i>)		43 MoReg 3266		
12 CSR 10-3.858	Director of Revenue (<i>Changed to 12 CSR 10-110.858</i>)		43 MoReg 3268		
12 CSR 10-3.876	Director of Revenue (<i>Changed to 12 CSR 10-103.876</i>)		43 MoReg 3266		
12 CSR 10-4.320	Director of Revenue (<i>Changed to 12 CSR 10-113.320</i>)		43 MoReg 3268		
12 CSR 10-10.120	Director of Revenue		43 MoReg 3268		
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12 CSR 10-23.180	Director of Revenue		43 MoReg 1330R	43 MoReg 2913R	
12 CSR 10-23.255	Director of Revenue		43 MoReg 1330R	43 MoReg 2913R	
12 CSR 10-23.260	Director of Revenue		This Issue		
12 CSR 10-23.270	Director of Revenue		43 MoReg 1330R	43 MoReg 2913R	
12 CSR 10-23.275	Director of Revenue		43 MoReg 1331R	43 MoReg 2913R	
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12 CSR 10-23.290	Director of Revenue		43 MoReg 1331R	43 MoReg 2914R	
12 CSR 10-23.340	Director of Revenue		This Issue		
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12 CSR 10-23.426	Director of Revenue		43 MoReg 1331R	43 MoReg 2914R	
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12 CSR 10-26.080	Director of Revenue		This Issue		
12 CSR 10-26.180	Director of Revenue		This Issue		
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12 CSR 10-26.200	Director of Revenue		43 MoReg 1332R	43 MoReg 2914R	
12 CSR 10-41.010	Director of Revenue	This Issue	This Issue		
12 CSR 10-42.060	Director of Revenue		43 MoReg 1332R	43 MoReg 2914R	
12 CSR 10-101.500	Director of Revenue		43 MoReg 3269		
12 CSR 10-103.017	Director of Revenue (<i>Changed from 12 CSR 10-3.017</i>)		43 MoReg 3266		
12 CSR 10-103.395	Director of Revenue		43 MoReg 3270		
12 CSR 10-103.700	Director of Revenue		43 MoReg 3270		
12 CSR 10-103.876	Director of Revenue (<i>Changed from 12 CSR 10-3.876</i>)		43 MoReg 3266		
12 CSR 10-110.858	Director of Revenue (<i>Changed from 12 CSR 10-3.858</i>)		43 MoReg 3268		
12 CSR 10-113.320	Director of Revenue (<i>Changed from 12 CSR 10-4.320</i>)		43 MoReg 3268		
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13 CSR	Department of Social Services				42 MoReg 990
13 CSR 5-2.010	Office of the Director (<i>Changed from 13 CSR 45-2.010</i>)		43 MoReg 2654		
13 CSR 10-3.010	Division of Finance and Administrative Services (<i>Changed from 13 CSR 35-100.010</i>)		43 MoReg 2544		
13 CSR 10-3.020	Division of Finance and Administrative Services (<i>Changed from 13 CSR 35-100.020</i>)		43 MoReg 2546		
13 CSR 10-3.030	Division of Finance and Administrative Services (<i>Changed from 13 CSR 35-100.030</i>)		43 MoReg 2549		
13 CSR 10-3.040	Division of Finance and Administrative Services (<i>Changed from 13 CSR 40-79.010</i>)		43 MoReg 2553		
13 CSR 10-3.050	Division of Finance and Administrative Services		43 MoReg 2543		
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13 CSR 15-19.010	Division of Aging		43 MoReg 2853R		
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13 CSR 30-2.030	Child Support Enforcement		43 MoReg 1168R	43 MoReg 3009R	
13 CSR 30-2.040	Child Support Enforcement		43 MoReg 1168R	43 MoReg 3009R	
13 CSR 30-4.020	Child Support Enforcement (<i>Changed to 13 CSR 40-104.010</i>)		43 MoReg 2648		
13 CSR 30-5.010	Child Support Enforcement (<i>Changed to 13 CSR 40-102.010</i>)		43 MoReg 2853		
13 CSR 30-5.020	Child Support Enforcement (<i>Changed to 13 CSR 40-106.010</i>)		43 MoReg 3072		
13 CSR 30-6.010	Child Support Enforcement (<i>Changed to 13 CSR 40-104.020</i>)		43 MoReg 3074		
13 CSR 30-7.010	Child Support Enforcement (<i>Changed to 13 CSR 40-100.020</i>)		43 MoReg 3075		
13 CSR 30-8.010	Child Support Enforcement (<i>Changed to 13 CSR 40-100.030</i>)		43 MoReg 2855		

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13 CSR 30-10.010	Child Support Enforcement (<i>Changed to 13 CSR 40-110.040</i>)		43 MoReg 2651		
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13 CSR 35-35.050	Children's Division (<i>Changed from 13 CSR 40-30.010</i>)		43 MoReg 2654		
13 CSR 35-60.030	Children's Division		43 MoReg 3081		
13 CSR 35-73.010	Children's Division (<i>Changed from 13 CSR 40-73.010</i>)		43 MoReg 2979		
13 CSR 35-73.012	Children's Division (<i>Changed from 13 CSR 40-73.012</i>)		43 MoReg 2857		
13 CSR 35-73.030	Children's Division (<i>Changed from 13 CSR 40-73.030</i>)		43 MoReg 2858		
13 CSR 35-73.035	Children's Division (<i>Changed from 13 CSR 40-73.035</i>)		43 MoReg 2979		
13 CSR 35-73.040	Children's Division (<i>Changed from 13 CSR 40-73.040</i>)		43 MoReg 2980		
13 CSR 35-73.050	Children's Division (<i>Changed from 13 CSR 40-73.050</i>)		43 MoReg 2980		
13 CSR 35-73.060	Children's Division (<i>Changed from 13 CSR 40-73.060</i>)		43 MoReg 2981		
13 CSR 35-73.070	Children's Division (<i>Changed from 13 CSR 40-73.070</i>)		43 MoReg 2981		
13 CSR 35-73.075	Children's Division (<i>Changed from 13 CSR 40-73.075</i>)		43 MoReg 2981		
13 CSR 35-73.080	Children's Division (<i>Changed from 13 CSR 40-73.080</i>)		43 MoReg 2982		
13 CSR 35-100.010	Children's Division (<i>Changed to 13 CSR 10-3.010</i>)		43 MoReg 2544		
13 CSR 35-100.020	Children's Division (<i>Changed to 13 CSR 10-3.020</i>)		43 MoReg 2546		
13 CSR 35-100.030	Children's Division (<i>Changed to 13 CSR 10-3.030</i>)		43 MoReg 2549		
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13 CSR 40-2.020	Family Support Division		43 MoReg 3082		
13 CSR 40-2.040	Family Support Division		43 MoReg 3082		
13 CSR 40-2.050	Family Support Division		43 MoReg 2653		
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13 CSR 40-2.100	Family Support Division		43 MoReg 2653		
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13 CSR 40-2.200	Family Support Division		43 MoReg 3084		
13 CSR 40-2.260	Family Support Division		43 MoReg 3085		
13 CSR 40-2.375	Family Support Division		43 MoReg 2552R		
13 CSR 40-2.395	Family Support Division		43 MoReg 3086		
13 CSR 40-3.020	Family Support Division (<i>Changed to 13 CSR 40-108.020</i>)		43 MoReg 2653		
13 CSR 40-7.010	Family Support Division		43 MoReg 3087		
13 CSR 40-7.015	Family Support Division		43 MoReg 1169	43 MoReg 3009	
13 CSR 40-7.020	Family Support Division		43 MoReg 2654		
13 CSR 40-7.070	Family Support Division		43 MoReg 2552		
13 CSR 40-30.010	Family Support Division (<i>Changed to 13 CSR 35-35.050</i>)		43 MoReg 2654		
13 CSR 40-32.020	Family Support Division		43 MoReg 2856R		
13 CSR 40-34.012	Family Support Division		43 MoReg 1917R		
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13 CSR 40-36.001	Family Support Division		43 MoReg 2857R		
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13 CSR 40-73.010	Family Support Division (<i>Changed to 13 CSR 35-73.010</i>)		43 MoReg 2979		
13 CSR 40-73.012	Family Support Division (<i>Changed to 13 CSR 35-73.012</i>)		43 MoReg 2857		
13 CSR 40-73.015	Family Support Division		43 MoReg 2857R		
13 CSR 40-73.018	Family Support Division		43 MoReg 2858R		
13 CSR 40-73.030	Family Support Division (<i>Changed to 13 CSR 35-73.030</i>)		43 MoReg 2858		
13 CSR 40-73.035	Family Support Division (<i>Changed to 13 CSR 35-73.035</i>)		43 MoReg 2979		
13 CSR 40-73.040	Family Support Division (<i>Changed to 13 CSR 35-73.040</i>)		43 MoReg 2980		
13 CSR 40-73.050	Family Support Division (<i>Changed to 13 CSR 35-73.050</i>)		43 MoReg 2980		
13 CSR 40-73.060	Family Support Division (<i>Changed to 13 CSR 35-73.060</i>)		43 MoReg 2981		
13 CSR 40-73.070	Family Support Division (<i>Changed to 13 CSR 35-73.070</i>)		43 MoReg 2981		
13 CSR 40-73.075	Family Support Division (<i>Changed to 13 CSR 35-73.075</i>)		43 MoReg 2981		
13 CSR 40-73.080	Family Support Division (<i>Changed to 13 CSR 35-73.080</i>)		43 MoReg 2982		
13 CSR 40-79.010	Family Support Division (<i>Changed to 13 CSR 10-3.040</i>)		43 MoReg 2553		
13 CSR 40-80.010	Family Support Division		43 MoReg 2555R		
13 CSR 40-91.010	Family Support Division		43 MoReg 3089		
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13 CSR 40-100.020	Family Support Division (<i>Changed from 13 CSR 30-7.010</i>)		43 MoReg 3075		
13 CSR 40-100.030	Family Support Division (<i>Changed from 13 CSR 30-8.010</i>)		43 MoReg 2855		

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13 CSR 40-104.010	Family Support Division (Changed from 13 CSR 30-4.020)		43 MoReg 2648		
13 CSR 40-104.020	Family Support Division (Changed from 13 CSR 30-6.010)		43 MoReg 3074		
13 CSR 40-106.010	Family Support Division (Changed from 13 CSR 30-5.020)		43 MoReg 3072		
13 CSR 40-108.020	Family Support Division (Changed from 13 CSR 40-3.020)		43 MoReg 2653		
13 CSR 40-108.030	Family Support Division (Changed from 13 CSR 30-9.010)		43 MoReg 2650		
13 CSR 40-108.040	Family Support Division (Changed from 13 CSR 30-2.010)		43 MoReg 2645		
13 CSR 40-110.040	Family Support Division (Changed from 13 CSR 30-10.010)		43 MoReg 2651		
13 CSR 45-2.010	Division of Legal Services (Changed to 13 CSR 5-2.010)		43 MoReg 2654		
13 CSR 65-3.010	Missouri Medicaid Audit and Compliance		43 MoReg 2555		
13 CSR 65-3.060	Missouri Medicaid Audit and Compliance		43 MoReg 2858		
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13 CSR 70-10.120	MO HealthNet Division		43 MoReg 2661		
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13 CSR 70-15.110	MO HealthNet Division	43 MoReg 1994	43 MoReg 2315	This Issue	
13 CSR 70-15.160	MO HealthNet Division		43 MoReg 1170	43 MoReg 3130	
13 CSR 70-20.030	MO HealthNet Division		43 MoReg 2868		
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13 CSR 70-20.340	MO HealthNet Division		43 MoReg 3099		
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13 CSR 70-30.010	MO HealthNet Division		43 MoReg 3103		
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13 CSR 70-98.015	MO HealthNet Division		43 MoReg 3103		
13 CSR 70-98.020	MO HealthNet Division		43 MoReg 3105		
13 CSR 110-2.030	Division of Youth Services		43 MoReg 1177	43 MoReg 3010	
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13 CSR 110-2.050	Division of Youth Services		43 MoReg 1178	43 MoReg 3010	
13 CSR 110-2.060	Division of Youth Services		43 MoReg 2662		
13 CSR 110-2.080	Division of Youth Services		43 MoReg 1179	43 MoReg 3010	
13 CSR 110-2.100	Division of Youth Services		43 MoReg 1179	43 MoReg 3010	
13 CSR 110-2.120	Division of Youth Services		43 MoReg 2663		
13 CSR 110-2.130	Division of Youth Services		43 MoReg 1180	43 MoReg 3011	
13 CSR 110-3.010	Division of Youth Services		43 MoReg 3106		
13 CSR 110-3.015	Division of Youth Services		43 MoReg 2868R		
13 CSR 110-3.020	Division of Youth Services		43 MoReg 2869R		
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17 CSR	Board of Police Commissioners				43 MoReg 1498

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19 CSR 30-1.078	Division of Regulation and Licensure	43 MoReg 2972	43 MoReg 2991		
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19 CSR 73-2.053	Missouri Board of Nursing Home Administrators		43 MoReg 2876		
19 CSR 73-2.060	Missouri Board of Nursing Home Administrators		43 MoReg 2877		
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20 CSR	Caps for Medical Malpractice				43 MoReg 1376
20 CSR	Construction Claims Binding Arbitration Cap				42 MoReg 1851
20 CSR	Sovereign Immunity Limits				42 MoReg 1851
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20 CSR 200-3.010	Insurance Solvency and Company Regulation		This Issue		
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20 CSR 200-4.010	Insurance Solvency and Company Regulation		This Issue		
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20 CSR 200-17.200	Insurance Solvency and Company Regulation		This Issue		
20 CSR 200-19.020	Insurance Solvency and Company Regulation		This Issue		
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20 CSR 2015-2.010	Acupuncturist Advisory Committee		43 MoReg 1455	43 MoReg 3145	
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20 CSR 2015-4.020	Acupuncturist Advisory Committee		43 MoReg 1458	43 MoReg 3146	
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20 CSR 2030-5.010	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		43 MoReg 1458	43 MoReg 3147	
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20 CSR 2030-5.080	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		43 MoReg 1460	43 MoReg 3147	
20 CSR 2030-5.090	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		43 MoReg 1461	43 MoReg 3147	
20 CSR 2030-5.100	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		43 MoReg 1461	43 MoReg 3148W	
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20 CSR 2030-5.160	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		43 MoReg 1463	43 MoReg 3149	
20 CSR 2030-6.015	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		43 MoReg 1464	43 MoReg 3149	
20 CSR 2030-6.020	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		43 MoReg 1468	43 MoReg 3149	
20 CSR 2030-8.020	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		43 MoReg 1471	43 MoReg 3149	
20 CSR 2030-10.010	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		43 MoReg 1471	43 MoReg 3150	
20 CSR 2030-15.020	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		43 MoReg 1472	43 MoReg 3150	
20 CSR 2030-21.010	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		43 MoReg 1473	43 MoReg 3150	
20 CSR 2030-21.020	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		43 MoReg 1473	43 MoReg 3150	
20 CSR 2040-2.011	Office of Athletics	43 MoReg 2772	43 MoReg 2878		
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20 CSR 2065-1.020	Endowed Care Cemeteries		43 MoReg 1332R	43 MoReg 2914R	
20 CSR 2065-1.030	Endowed Care Cemeteries		43 MoReg 1333	43 MoReg 2915	
20 CSR 2065-1.050	Endowed Care Cemeteries		43 MoReg 1333	43 MoReg 2915	
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20 CSR 2065-2.050	Endowed Care Cemeteries		43 MoReg 1335	43 MoReg 2916	
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20 CSR 2095-1.020	Committee for Professional Counselors		43 MoReg 3108		
20 CSR 2110-1.010	Missouri Dental Board		43 MoReg 3111		
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*4 CSR 80—Economic Development Programs is changing to Division of Economic Development Programs.

*10 CSR 23—Division of Geology and Land Survey is changing to Well Installation.

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1 CSR 20-1.010	General Organization43 MoReg 2735	Aug. 28, 2018Feb. 28, 2019
1 CSR 20-1.020	Definitions43 MoReg 2736	Aug. 28, 2018Feb. 28, 2019
1 CSR 20-1.040	Unclassified Service43 MoReg 2740	Aug. 28, 2018Feb. 28, 2019
1 CSR 20-1.045	Covered Service43 MoReg 2741	Aug. 28, 2018Feb. 28, 2019
1 CSR 20-2.010	The Classification Plan43 MoReg 2742	Aug. 28, 2018Feb. 28, 2019
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1 CSR 20-2.020	The Pay Plan43 MoReg 2747	Aug. 28, 2018Feb. 28, 2019
1 CSR 20-3.010	Examinations43 MoReg 2749	Aug. 28, 2018Feb. 28, 2019
1 CSR 20-3.020	Registers43 MoReg 2753	Aug. 28, 2018Feb. 28, 2019
1 CSR 20-3.030	Certification and Appointment43 MoReg 2754	Aug. 28, 2018Feb. 28, 2019
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1 CSR 20-3.070	Separation, Suspension, and Demotion43 MoReg 2759	Aug. 28, 2018Feb. 28, 2019
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1 CSR 20-4.010	Appeals43 MoReg 2764	Aug. 28, 2018Feb. 28, 2019
1 CSR 20-4.020	Grievance Procedures43 MoReg 2764	Aug. 28, 2018Feb. 28, 2019
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1 CSR 40-1.050	Procedures for Solicitation, Receipt of Bids, and Award and Administration of Contracts43 MoReg 2967	Sept. 15, 2018March. 13, 2019
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1 CSR 50-5.010	Definitions43 MoReg 1121	Aug. 8, 2018Feb. 4, 2019
1 CSR 50-5.020	Registration Requirements for Committees Domiciled Outside the State of Missouri and Out-of-State Committees43 MoReg 1121	Aug. 8, 2018Feb. 4, 2019
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8 CSR 30-3.010	Applicable Wage Rates for Public Works Projects	Jan. 2, 2019 Issue	Dec. 01, 2018May 29, 2019
8 CSR 30-3.030	Apprentices and Entry-Level Workers	Jan. 2, 2019 Issue	Dec. 01, 2018May 29, 2019
8 CSR 30-3.040	Classifications of Construction Work	Jan. 2, 2019 Issue	Dec. 01, 2018May 29, 2019
8 CSR 30-3.050	Posting of Prevailing Wage Rates	Jan. 2, 2019 Issue	Dec. 01, 2018May 29, 2019
8 CSR 30-3.060	Occupational Titles of Work Descriptions	Jan. 2, 2019 Issue	Dec. 01, 2018May 29, 2019
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11 CSR 70-2.240	Advertising of Intoxicating Liquor43 MoReg 3199	Oct. 20, 2018April 17, 2019
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12 CSR 10-41.010	Annual Adjusted Rate of Interest	This Issue	Jan. 1, 2019June 29, 2019
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19 CSR 10-10.130 Missouri Adoptee Rights	43 MoReg 2967	Sept. 20, 2018	March 18, 2019
19 CSR 10-15.060 Prohibition on Expenditure of Funds	43 MoReg 2456	July 15, 2018	Feb. 28, 2019
19 CSR 30-1.002 Schedules of Controlled Substances	This Issue	Nov. 04, 2018	May 2, 2019
19 CSR 30-1.023 Registration Changes	43 MoReg 2970	Sept 27, 2018	March 25, 2019
19 CSR 30-1.064 Partial Filling of Controlled Substance Prescriptions	43 MoReg 2971	Sept 27, 2018	March 25, 2019
19 CSR 30-1.078 Disposing of Unwanted Controlled Substances	43 MoReg 2972	Sept 27, 2018	March 25, 2019
Department of Insurance, Financial Institutions and Professional Registration			
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20 CSR 2040-2.011 Licenses	43 MoReg 2772	Sept. 7, 2018	March 5, 2019
20 CSR 2040-2.021 Permits	43 MoReg 2772	Sept. 7, 2018	March 5, 2019
Board of Cosmetology and Barber Examiners			
20 CSR 2085-3.010 Fees	43 MoReg 3058	Oct. 1, 2018	March. 29, 2019
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20 CSR 2110-2.250 Prescribing Opioids	Next Issue	Nov. 17, 2018	May 15, 2019
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20 CSR 2150-3.080 Physical Therapists Licensure Fees	43 MoReg 2459	July 13, 2018	Feb. 28, 2019
20 CSR 2150-3.170 Physical Therapist Assistant Licensure Fees	43 MoReg 2459	July 13, 2018	Feb. 28, 2019
20 CSR 2150-3.300 Physical Therapy Compact Rules	43 MoReg 2460	July 13, 2018	Feb. 28, 2019
20 CSR 2150-5.100 Collaborative Practice	43 MoReg 977	April 26, 2018	Feb. 5, 2019
20 CSR 2150-5.100 Collaborative Practice	Jan. 2, 2019 Issue	Nov. 20, 2018	Term. Feb. 5, 2019
20 CSR 2150-5.025 Administration of Vaccines Per Protocol	43 MoReg 2773	Sept. 30, 2018	March. 28, 2019
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20 CSR 2200-4.200 Collaborative Practice	43 MoReg 977	April 26, 2018	Feb. 5, 2019
20 CSR 2200-4.200 Collaborative Practice	Jan. 2, 2019 Issue	Nov. 20, 2018	Term. Feb. 5, 2019
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20 CSR 2210-2.070 Fees	43 MoReg 1257	May 21, 2018	Feb. 28, 2019
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20 CSR 2220-2.200 Sterile Compounding	43 MoReg 2776	Aug. 30, 2018	Feb. 28, 2019
20 CSR 2220-4.010 General Fees	43 MoReg 3058	March 30, 2018 Term.	Sept. 24, 2018
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20 CSR 2231-3.010 Fee Waiver for Military Families and Low-Income Individuals	Next Issue	Nov. 17, 2018	May 15, 2019
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20 CSR 2232-1.040 Fees	Next Issue	Nov. 17, 2018	May 15, 2019
Real Estate Appraisers			
20 CSR 2245-1.010 General Organization	43 MoReg 2639	Aug 17, 2018	Feb. 28, 2019
20 CSR 2245-3.005 Trainee Real Estate Appraiser Registration	43 MoReg 2640	Aug 17, 2018	Feb. 28, 2019
20 CSR 2245-3.010 Applications for Certification and Licensure	43 MoReg 2641	Aug 17, 2018	Feb. 28, 2019
20 CSR 2245-6.040 Case Study Courses	43 MoReg 2642	Aug 17, 2018	Feb. 28, 2019
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20 CSR 2245-8.030 Instructor Approval	43 MoReg 2643	Aug 17, 2018	Feb. 28, 2019
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22 CSR 10-1.030 Board of Trustees Election Process	This Issue	Jan 1, 2019	June. 29, 2019
22 CSR 10-2.010 Definitions	This Issue	Jan 1, 2019	June. 29, 2019
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22 CSR 10-2.046 PPO 750 Plan Benefit Provisions and Covered Charges	This Issue	Jan 1, 2019	June. 29, 2019
22 CSR 10-2.047 PPO 1250 Plan Benefit Provisions and Covered Charges	This Issue	Jan 1, 2019	June. 29, 2019
22 CSR 10-2.051 PPO 300 Plan Benefit Provisions and Covered Charges	This Issue	Jan 1, 2019	June. 29, 2019
22 CSR 10-2.052 PPO 600 Plan Benefit Provisions and Covered Charges	This Issue	Jan 1, 2019	June. 29, 2019
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22 CSR 10-2.090 Pharmacy Benefit SummaryThis Issue	Jan 1, 2019 . . .	June. 29, 2019
22 CSR 10-2.110 General Foster Parent Membership ProvisionsThis Issue	Jan 1, 2019 . . .	June. 29, 2019
22 CSR 10-2.140 Strive for Wellness® Health Center Provisions, Charges, and ServicesThis Issue	Jan 1, 2019 . . .	June. 29, 2019
22 CSR 10-3.010 DefinitionsThis Issue	Jan 1, 2019 . . .	June. 29, 2019
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18-09	Closes state offices November 23, 2018.	Nov. 1, 2018	43 MoReg 3204
18-08	Establishes the Missouri Justice Reinvestment Executive Oversight Council.	Oct. 25, 2018	This Issue
Proclamation	Governor temporarily reduces line items in the budget.	Oct. 31, 2018	This Issue
18-07	Establishes the Bicentennial Commission.	Oct. 12, 2018	43 MoReg 3202
Proclamation	Calls upon the Senators and Representatives to enact legislation requiring the Department of Elementary and Secondary Education to establish a statewide program to be known as the "STEM Career Awareness Program."	Sept. 4, 2018	43 MoReg 2780
18-06	Designates those members of the governor's staff who have supervisory authority over each department, division, or agency of state government.	Aug. 21, 2018	43 MoReg 2778
18-05	Declares a drought alert for 47 Missouri counties and orders the director of the Department of Natural Resources to activate and designate a chairperson for the Drought Assessment Committee	July 18, 2018	43 MoReg 2539
18-04	Extends the deadline from Section 3d of Executive Order 17-03 through September 30, 2018.	June 29, 2018	43 MoReg 1996
18-03	Reauthorizes and restructures the Homeland Security Advisory Council.	April 25, 2018	43 MoReg 1123
18-02	Declares a State of Emergency and activates the state militia in response to severe weather that began on Feb. 23.	Feb. 24, 2018	43 MoReg 664
Proclamation	Governor notifies the General Assembly that he is reducing appropriation lines in the fiscal year 2018 budget.	Feb. 14, 2018	43 MoReg 519
18-01	Rescinds Executive Order 07-21.	Jan. 4, 2018	43 MoReg 251

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17-24	Designates members of the governor's staff to have supervisory authority over departments, divisions, and agencies of state government.	Nov. 17, 2017	43 MoReg 5
17-23	Advises that state offices will be closed on Friday, November 24, 2017.	Nov. 1, 2017	42 MoReg 1640
17-22	Implements the Emergency Mutual Assistance Compact and activates the state militia to aid the U.S. Virgin Islands in response to Hurricane Maria.	Sept. 20, 2017	42 MoReg 1579
17-21	Governor activates the state militia in anticipation of unrest in the St. Louis region.	Sept. 14, 2017	42 MoReg 1411
17-20	Governor establishes a board of inquiry to review evidence and provide a recommendation on the death sentence for inmate Marcellus Williams.	Aug. 22, 2017	42 MoReg 1361
Proclamation	Governor notifies the General Assembly that he is reducing appropriation lines in the fiscal year 2018 budget and permanently reducing appropriation lines in the fiscal year 2017 budget.	Aug. 1, 2017	42 MoReg 1307
17-19	Directs the Department of Health and Senior Services, the Department of Mental Health, the Department of Public Safety, the Department of Natural Resources, and the Department of Conservation to identify, train, equip, and assess law enforcement and emergency responder efforts to combat Missouri's Opioid Public Health Crisis.	July 18, 2017	42 MoReg 1229
17-18	Directs the Department of Health and Senior Services to create a prescription drug monitoring program.	July 17, 2017	42 MoReg 1143
Amended Proclamation	Governor convenes the Second Extra Session of the First Regular Session of the Ninety-Ninth General Assembly regarding abortions facilities.	July 6, 2017	42 MoReg 1139
17-17	Creates the Missouri Justice Reinvest Taskforce to analyze Missouri's corrections system and recommend improvements.	June 28, 2017	42 MoReg 1067
Proclamation	Governor convenes the Second Extra Session of the First Regular Session of the Ninety-Ninth General Assembly regarding abortions facilities.	June 7, 2017	42 MoReg 1024
Proclamation	Governor convenes the First Extra Session of the First Regular Session of the Ninety-Ninth General Assembly regarding attracting new jobs to Missouri.	May 18, 2017	42 MoReg 1022
17-16	Temporarily grants the Director of the Missouri Department of Revenue discretionary authority to adjust certain rules and regulations.	May 11, 2017	42 MoReg 909
17-15	Temporarily grants the Director of the Missouri Department of Health and Senior Services discretionary authority to adjust certain rules and regulations.	May 8, 2017	42 MoReg 907

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17-14	Temporarily grants the Director of the Missouri Department of Natural Resources discretionary authority to adjust certain environmental rules and regulations.	May 4, 2017	42 MoReg 905
17-13	Activates the state militia in response to severe weather that began on April 28, 2017.	April 30, 2017	42 MoReg 865
17-12	Declares a State of Emergency and activates the Missouri State Emergency Operations Plan due to severe weather beginning on April 28, 2017.	April 28, 2017	42 MoReg 863
17-11	Establishes the Boards and Commissions Task Force to recommend comprehensive executive and legislative reform proposals to the governor by October 31, 2017.	April 11, 2017	42 MoReg 779
17-10	Designates members of the governor's staff to have supervisory authority over departments, divisions, and agencies of state government.	April 7, 2017	42 MoReg 777
17-09	Establishes parental leave for state employees of the executive branch of Missouri state government and encourages other state officials to adopt comparable policies.	March 13, 2017	42 MoReg 429
17-08	Declares a State of Emergency and activates the Missouri State Emergency Operations Plan due to severe weather that began on March 6.	March 7, 2017	42 MoReg 427
17-07	Establishes the Governor's Committee for Simple, Fair, and Low Taxes to recommend proposed reforms to the governor by June 30, 2017.	January 25, 2017	42 MoReg 315
17-06	Orders that the Missouri State Emergency Operations Plan be activated. Further orders state agencies to provide assistance to the maximum extent practicable and directs the Adjutant General to call into service such portions of the organized militia as he deems necessary.	January 12, 2017	42 MoReg 267
17-05	Activates the Missouri State Emergency Operation Center due to severe weather expected to begin on Jan. 12, 2017.	January 11, 2017	42 MoReg 266
17-04	Establishes the position of Chief Operating Officer to report directly to the governor and serve as a member of the governor's executive team.	January 11, 2017	42 MoReg 264
17-03	Orders every state agency to immediately suspend all rulemaking until Feb. 28, 2017, and to complete a review of every regulation under its jurisdiction within the <i>Code of State Regulations</i> by May 31, 2018.	January 10, 2017	42 MoReg 261
17-02	Orders state employees of the executive branch of Missouri state government to follow a specified code of conduct regarding ethics during the Greitens administration.	January 9, 2017	42 MoReg 258
17-01	Rescinds Executive Orders 07-10, 88-26, 98-15, and 05-40 regarding the Governor's Advisory Council on Physical Fitness and Health and the Missouri State Park Advisory Board.	January 6, 2017	42 MoReg 257

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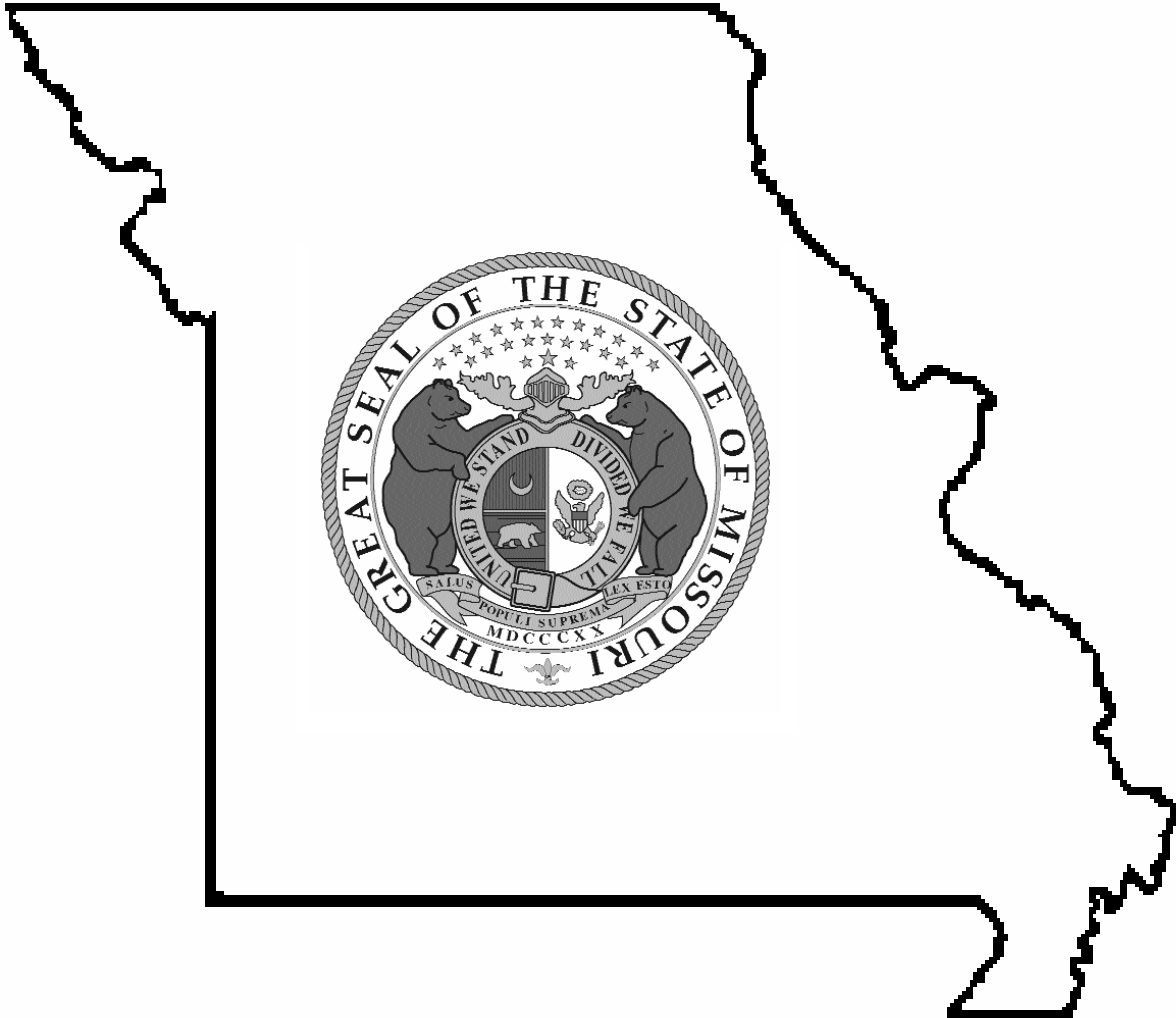
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